



# THE UNIVERSITY *of* EDINBURGH

This thesis has been submitted in fulfilment of the requirements for a postgraduate degree (e.g. PhD, MPhil, DClinPsychol) at the University of Edinburgh. Please note the following terms and conditions of use:

This work is protected by copyright and other intellectual property rights, which are retained by the thesis author, unless otherwise stated.

A copy can be downloaded for personal non-commercial research or study, without prior permission or charge.

This thesis cannot be reproduced or quoted extensively from without first obtaining permission in writing from the author.

The content must not be changed in any way or sold commercially in any format or medium without the formal permission of the author.

When referring to this work, full bibliographic details including the author, title, awarding institution and date of the thesis must be given.



THE UNIVERSITY  
*of* EDINBURGH

**Two investigations into fatherhood:**

**Paternal postpartum depression and paternal substance use**

**Luisa Sophie Frei**

**Doctorate in Clinical Psychology**

**University of Edinburgh**

**August 2016**

## DClinPsychol Declaration of Own Work

**Name:** Luisa Sophie Frei

**Title of Work:** Two investigations into fatherhood: paternal postpartum depression and paternal substance use

*I confirm that this work is my own except where indicated, and that I have:*

- Read and understood the Plagiarism Rules and Regulations
  - Composed and undertaken the work myself
  - Clearly referenced/listed all sources as appropriate
  - Referenced and put in inverted commas any quoted text of more than three words (from books, web, etc.)
  - Given the sources of all pictures, data etc. that are not my own
  - Not made undue use of essay(s) of any other student(s), either past or present (or where used, this has been referenced appropriately)
  - Not sought or used the help of any external professional agencies for the work (or where used, this has been referenced appropriately)
  - Not submitted the work for any other degree or professional qualification except as specified
  - Acknowledged in appropriate places any help that I have received from others (e.g. fellow students, technicians, statisticians, external sources)
  - Complied with other plagiarism criteria specified in the Programme Handbook
  - I understand that any false claim for this work will be penalised in accordance with the University regulations
  - Received ethical approval from the School of Health in Social Science, University of Edinburgh
- OR
- Received ethical approval from an approved external body and registered this application and confirmation of approval with the School of Health in Social Science's Ethical Committee

**Signature** .....

**Date** .....

### **Please note:**

- If you need further guidance on plagiarism, you can:
  - Speak to your personal tutor or supervisor
- View university regulations at <http://www.ed.ac.uk/schools-departments/academic-services/policies-regulations>
- Referencing for most assessed work should be in the format of the BPS style guide, which is freely available from the BPS web site

## Acknowledgements

**Thank you...**

**Jill** – for your consistent and invaluable academic, reflective and emotional support throughout these three years, for giving me deadlines when I needed them and for giving me time off when things got too much. Just what I needed!

**Roisin** – first and foremost, for your amazing enthusiasm and appreciation of my project! I valued our reflective and academic discussions very much.

**Heather, Sheilagh, Ethel and Anne** – for your constructive advice at the beginning stages of the empirical project.

**My colleagues in the SMD** – for your help with recruitment in a difficult to engage population. I really appreciated your efforts!

**My study participants** – for letting me into your thoughts. It would not have been possible without you.

**My friends, old and new** – for a healthy work – life balance, for your support and distraction in tough times, for your understanding when I did not have time for you, and your practical advice in all things ‘course and beyond’.

**My family** – I am lucky to have such a great family, who did and still does meet all my needs.

**Przemek** – for being there and choosing to spend your life with me.



## Table of Contents

Main Abstract .....	6
Lay Summary .....	7
1. Psychosocial risk factors for postpartum depression in fathers: A systematic review of longitudinal studies .....	8
Abstract .....	9
Highlights .....	9
1.1 Introduction .....	10
1.2 Methods .....	12
<i>Search Strategy</i> .....	12
<i>Study Inclusion Criteria</i> .....	12
<i>Study Exclusion Criteria</i> .....	13
<i>Quality Appraisal of Studies</i> .....	14
1.3 Findings .....	25
<i>Father-Infant Bonding</i> .....	25
<i>Birth Concerns</i> .....	25
<i>Parenting Related Risk Factors</i> .....	26
<i>Social Support Variables</i> .....	28
<i>Marital/Partner/Family Variables</i> .....	29
<i>Individual Variables</i> .....	30
1.4 Discussion .....	31
<i>Recommendations for Clinical Practice</i> .....	32
<i>Limitations</i> .....	33
<i>Conclusions</i> .....	34
<i>Acknowledgements</i> .....	34
<i>Funding</i> .....	34
<i>Declaration of Interest</i> .....	34
1.5 References .....	35
2. Bridging Chapter .....	39
2.1 References .....	40
3. ‘Hands on when able’: How opiate using fathers make sense of their parenting experience.....	41

Abstract .....	42
Highlights .....	42
3.1 Introduction .....	43
3.2 Methods .....	45
<i>Participants</i> .....	45
<i>Procedure</i> .....	45
<i>Data Analysis</i> .....	46
<i>Reflective Notes</i> .....	47
<i>Ethical Approval</i> .....	47
3.3 Findings .....	48
<i>The Disabled Father</i> .....	48
<i>The Able Father</i> .....	52
<i>Connecting the Dots</i> .....	54
3.4 Discussion .....	57
<i>Limitations</i> .....	59
<i>Conclusions</i> .....	59
<i>Funding Sources</i> .....	60
<i>Declaration of Interest</i> .....	60
3.5 References .....	61
Appendix .....	63

## Main Abstract

Historically, in many areas of research examining birth and parenthood the role of the mother often took precedence over the role of the father. This may be because, within a traditional family system, the father took the role of the provider, while the mother was responsible for child care and household. Societal and cultural changes over the past few decades have highlighted the importance and competence of fathers in less traditional roles and scientific research is currently aiming to fill the gap of knowledge pertaining to fatherhood. One field of research that has traditionally been neglected in fathers is postpartum depression (PPD), even though prevalence rates for fathers were estimated to be almost as high as for mothers. Research into the risk factors for paternal PPD has only grown substantially within the past two decades. The first part of this thesis provides a systematic review of the available evidence for psychosocial risk factors in the development of paternal PPD as examined by longitudinal research designs. Results of the review indicated that there was a general lack of high quality research, but there was some evidence for higher risk of PPD if fathers experienced disconfirmed expectations of parenting demands, low parenting efficacy, low relationship satisfaction, concerns/anxiety about the birth, disagreement about pregnancy intendedness, low prenatal life satisfaction and stress, and high role strain. The results were discussed in the context of implications for antenatal interventions for fathers. The second part of this thesis was concerned with another neglected group of fathers – fathers who were addicted to opiate drugs. While there is a large research base for the risk to children exposed to parental substance use, fathers' views on their parenting role and the cross-generational transmission of risk of child maltreatment and substance use has only partially been examined. Using Interpretative Phenomenological Analysis with a small sample of opiate-using fathers ( $N = 6$ ), it was found that fathers experienced dichotomy in their father role. Their addiction caused them to be 'disabled' in their father role, characterised by selfishness, abandonment and an inability to meet their children's needs. In contrast, the 'Able Father' came to light during stable periods of prescribed opiates or abstinence, and he was an involved, hands-on parent, sensitive to the child's needs and motivated to repair the ill-effects of being 'disabled' by addiction. By 'Connecting the Dots' with their own upbringing, fathers were motivated to be better fathers than their own fathers, but they only had limited insight into the risk their 'disabled' parenting posed for their own children. The findings suggest that harnessing fathers' motivation to be better fathers may be a useful asset in drug treatment and parenting interventions. Interventions aimed at increasing reflective functioning may contribute to positive outcomes for substance-using parents at the same time as reducing risk to their children, but more evidence is needed.

## Lay Summary

In the past, fathers have often been overlooked in research areas that were concerned with child birth and parenthood. This is slowly changing, but there are still gaps in the scientific knowledge about fatherhood. This thesis consists of two parts. The first part is concerned with understanding possible reasons for fathers becoming depressed during the first year after their child is born. Existing research suggested that fathers are more likely to become depressed, if their expectations about parenting were not fulfilled, if they felt they were not as good a parent as they thought they would be, or if they found it stressful to be a good father while having to provide for the family. Other reasons may be that they became unhappy in their relationship or were very worried about their partner during child birth. Finally, fathers who disagreed with their partners about whether the pregnancy was intended, or who were quite stressed and unsatisfied with their life before having a child, were also more at risk of becoming depressed. More research is needed to strengthen these findings. The second part of this thesis was a research study about fathers who use drugs. People often think that fathers who use drugs are selfish and unable to care for their children. Their children often suffer from their father's drug use. During interviews, these fathers spoke about their experience of being fathers and how they themselves experienced childhood. It was found that they perceived addiction like a disability, that prevented them from being better fathers. This motivated them to deal with their addiction and become a more 'Able Father'. They also said that they wanted to be better fathers than their own fathers had been. This meant they wanted to be there for their children, provide for them and have a good relationship with them. It seemed as if fathers did not realise that better parenting could protect their children from becoming drug users. Drug-using fathers might be helped in their recovery and their parenting by teaching them how to understand themselves and others better. Their motivation to be better fathers could also be used to help them overcome their addiction. These suggestions might help to protect children from the ill-effects of their father's drug use. More research is needed to support these suggestions.

# **1. Psychosocial risk factors for postpartum depression in fathers: A systematic review of longitudinal studies**

Luisa S. Frei<sup>1</sup> and Jill Cossar<sup>1</sup>

<sup>1</sup> University of Edinburgh, School of Health in Social Science

Corresponding Author:

Luisa S. Frei

Trainee Clinical Psychologist

School of Health in Social Sciences

The University of Edinburgh

Teviot Place

EDINBURGH

EH8 9AG

Email: s1370095@sms.ed.ac.uk

Phone: 0131 650 3889

This journal article is written for submission at the Journal of Affective Disorders (Appendix A).

Abstract word count: 225

Main text word count, excluding tables and references: 5002

## Abstract

**Background:** Despite an estimated prevalence of 10%, less is known about the risk for postpartum depression (PPD) in fathers than in mothers. The study of psychosocial risk factors can help identify points of intervention to prevent paternal PPD. This systematic review evaluates the evidence of longitudinal research of psychosocial risk factors for paternal PPD.

**Methods:** A systematic search yielded 18 studies that met the inclusion/exclusion criteria and that were appraised as having acceptable validity and reliability on the basis of pre-defined quality criteria.

**Results:** This review highlighted a number of psychosocial risk factors which predicted subsequent paternal PPD: disconfirmed expectations of parenting demands, low parenting efficacy, low relationship satisfaction, being concerned/anxious about the birth, disagreement about pregnancy intendedness, low prenatal life satisfaction and stress, and high role strain.

**Limitations:** Study selection and quality appraisal was only triangulated with independent raters for a subset of the studies. No meta-analysis was possible due to a variety of constructs, measures and samples.

**Conclusions:** Antenatal interventions for fathers that target fathers' expectations of their own role in parenting their children, concerns about the birth process, expectations of the impact of a child on the partner relationship, as well as prepare them for the difficulties and challenges associated with parenting may help prevent paternal PPD. More longitudinal research into the study of psychosocial risk factors for paternal PPD is needed.

**Keywords:** postpartum depression, postnatal depression, fathers, psychosocial risk factors, longitudinal, clinical recommendations

## Highlights

1. Evidence for psychosocial risk factors for paternal PPD was evaluated.
2. Unmet parenting expectations and efficacy increased the risk for paternal PPD.
3. Concerns about the birth process increased the risk for paternal PPD.
4. Low relationship satisfaction and quality increased the risk for paternal PPD.
5. Most psychosocial risk factors lacked sufficient high quality evidence.

## 1.1 Introduction

Parenthood is a significant event in most parents' lives. While most deal well with the practical and emotional challenges that come with infant care, some parents suffer from a deterioration in mental health. Postpartum depression (PPD) is a common phenomenon in mothers and fathers, with prevalence rates between 7-25% of depressive symptoms in women (Gotlib et al., 1989; Josefsson et al., 2001), and 4-25% in fathers (Escriba-Aguir and Artazcoz, 2011; Paulson and Bazemore, 2010), but suggesting an average of approximately 10% prevalence of birth-related depression for fathers during the first post-partum year (Edward et al., 2015; Paulson and Bazemore, 2010). Paulson and Bazemore (2010) also found that paternal depressive symptoms were relatively higher in the three to six month postpartum period than in any other period. While maternal postpartum depression has been studied for decades, the research base on paternal postpartum depression has only started growing substantially in the past 10-15 years. Several reviews have provided an insight into the overall findings in this area (Clare and Yeh, 2012; Edward et al., 2015; Singley and Edwards, 2015; Tuszyńska-Bogucka and Nawra, 2014; Wee et al., 2011). While most studies measured PPD using a cut-off in screening measures to determine case-ness, others looked at the continuum of postpartum depressive symptoms (PDS), including those fathers who may not fulfil diagnostic criteria but nevertheless suffer from some depressive symptoms.

Singley and Edwards (2015) provided an overview of the psychosocial theories relevant to the development of mental health difficulties in fathers during the perinatal period. They described social role changes over the past decades from the father as a moral and gender role model as well as a provider, to a father who in addition is also an active and nurturing caretaker, a "generative father" (Dollahite et al., 1997; Singley and Edwards, 2015). Singley and Edwards reasoned that contemporary fathers are caught in a "generation gap", where the father role they experienced with their own fathers is different from the role expectation of their present environment. They suggest that managing the new father role and associated expectations can lead to challenges and possibly mental health difficulties in the transition period to fatherhood (Singley and Edwards, 2015).

There is some evidence that postpartum depression in fathers may be associated with a variety of adverse outcomes for the child, parenting and the marital relationship, as well as the health care system (Sweeney and MacBeth, 2016). Bronte-Tinkew et al. (2007) found that major depression in fathers during the first postpartum year is negatively related to father-child engagement, marital relationship quality and co-parental relationship supportiveness, while leading to greater paternal aggravation and parenting stress.

Ramchandani et al. (2008) provided evidence that paternal postpartum depression is associated with higher child psychopathology during the first seven years. In addition, a

small study estimated that paternal depression was associated with significantly higher community care costs (Edoka et al., 2011).

The potentially negative effects of paternal PPD on parents and their offspring as well as the health care system inevitably leads to the question of prevention by identifying risk factors for early intervention. The evidence suggests that the strongest risk factors for paternal PPD are maternal pre- and postnatal depression and a personal history of depression (Areias et al., 1996; Edward et al., 2015; Wee et al., 2011). Demographic risk factors for paternal PDS/PPD have also been identified, such as having a substance use problem, being in a less stable or non-romantic relationship with the mother (Huang and Warner, 2005), belonging to manual or working class occupations (Areias et al., 1996), living in stepfamilies, lower educational qualifications, living in crowded, rented or low-income accommodation, older age, or unemployment (Deater-Deckard et al., 1998). Race as a risk factor is still inconclusive (Bronte-Tinkew et al., 2007). Potential psychosocial risk factors have also been identified including low social support, poor relationship quality, poor role adjustment, various life stressors, disappointed parenting expectations, or poor infant bonding (Edward et al., 2015; Wee et al., 2011). Psychosocial risk factors have been studied in cross-sectional as well as longitudinal designs. While it is impossible to determine causality for the risk factors of paternal PDS, longitudinal (rather than cross-sectional) designs can help establish a time line of predecessors of PDS/PPD and identify possible predictors (Sussman, 1964). This in turn can inform early psychosocial and clinical interventions for the prevention of the onset of paternal PDS and PPD.

The aim of this review was to identify psychosocial risk factors implicated in the development of PDS/PPD in fathers and evaluate the quality of evidence for these risk factors. We were particularly interested in the longitudinal study of risk factors (identifying statistical predictors), which could inform early psychosocial interventions for the prevention of PDS/PPD. Psychosocial rather than demographic risk factors were chosen as a focus for this review, because they are of higher clinical relevance for prophylactic intervention than demographic risk factors. There is ample evidence for past depression and partner depression as risk factors for postpartum depression, which is why these risk factors were excluded from the review. In addition, due to the high co-morbidity of other psychiatric conditions with depression, for example anxiety or PTSD symptoms (Rohde et al., 1991) and the fact that any psychiatric condition merits clinical intervention regardless of its impact on postpartum depression, these factors were also excluded.



## 1.2 Methods

### *Search Strategy*

A systematic search of databases was conducted using two search engines, EbscoHost and Ovid, including all articles until 14<sup>th</sup> May 2016. EbscoHost was used to search CINAHL PLUS, Academic Search Premier and Medline. Primary search terms were “Depression, postpartum” (with subheadings “Etiology”, “familial and genetic”, “Psychosocial factors” and “Risk factors”) and “Fathers” (with subheadings “Etiology”, “familial and genetic”, “Psychosocial factors”). The search was limited further with the parameters “male” and “academic journals”. The Ovid search engine was used to search the databases Embase, PsychInfo and GlobalHealth, with the search terms ((“postpartum depression”) OR (“postnatal depression”)) AND “Fathers”. A total of 1364 studies were identified, and then excluded based on their title/abstract and methodology. At the methodology screening stage, a subset of 18 studies (30.51% of studies) was screened by two independent raters (9 each). Interrater differences in the inclusion/exclusion of studies were discussed and consensus achieved, contributing to the final number of studies accepted. A further search was conducted by manually checking previous reviews, yielding three more eligible studies, coming to a total of 21 studies (Figure 1.1). For the purpose of bibliography management, we used Endnote X7. Microsoft Excel served as data management software and an online calculator was used to calculate interrater reliability and percentage agreement (<http://dfreelon.org/utills/recalfront/recal2/>).

### *Study Inclusion Criteria*

1. Outcome: depressive symptoms with and without cut-off for case-ness in fathers within the first 12 months after birth
2. Measuring psychosocial risk factors of PPD symptoms: Psychosocial risk factors are defined as risk factors that pertain to both the psychological and social domains. By this definition, “social class” would be excluded as it is only a social risk factor, whereas “life-time depression” would be excluded based on the assumption that it is purely a psychological risk factor.
3. Study design must be longitudinal (prospective or retrospective cohort study) with at least two time points of quantitative data
4. Testing for prediction or causality using regression, path analyses or structural equation modelling
5. Studies from peer-reviewed journals

*(continued on next page)*

6. Fathers of healthy, full-term infants
7. English language

*Study Exclusion Criteria:*

1. Studies that looked exclusively at demographic risk factors (e.g. age, gender, marital status, substance use, stressful life events, etc. )
2. Adolescent fathers (< 18 years old)

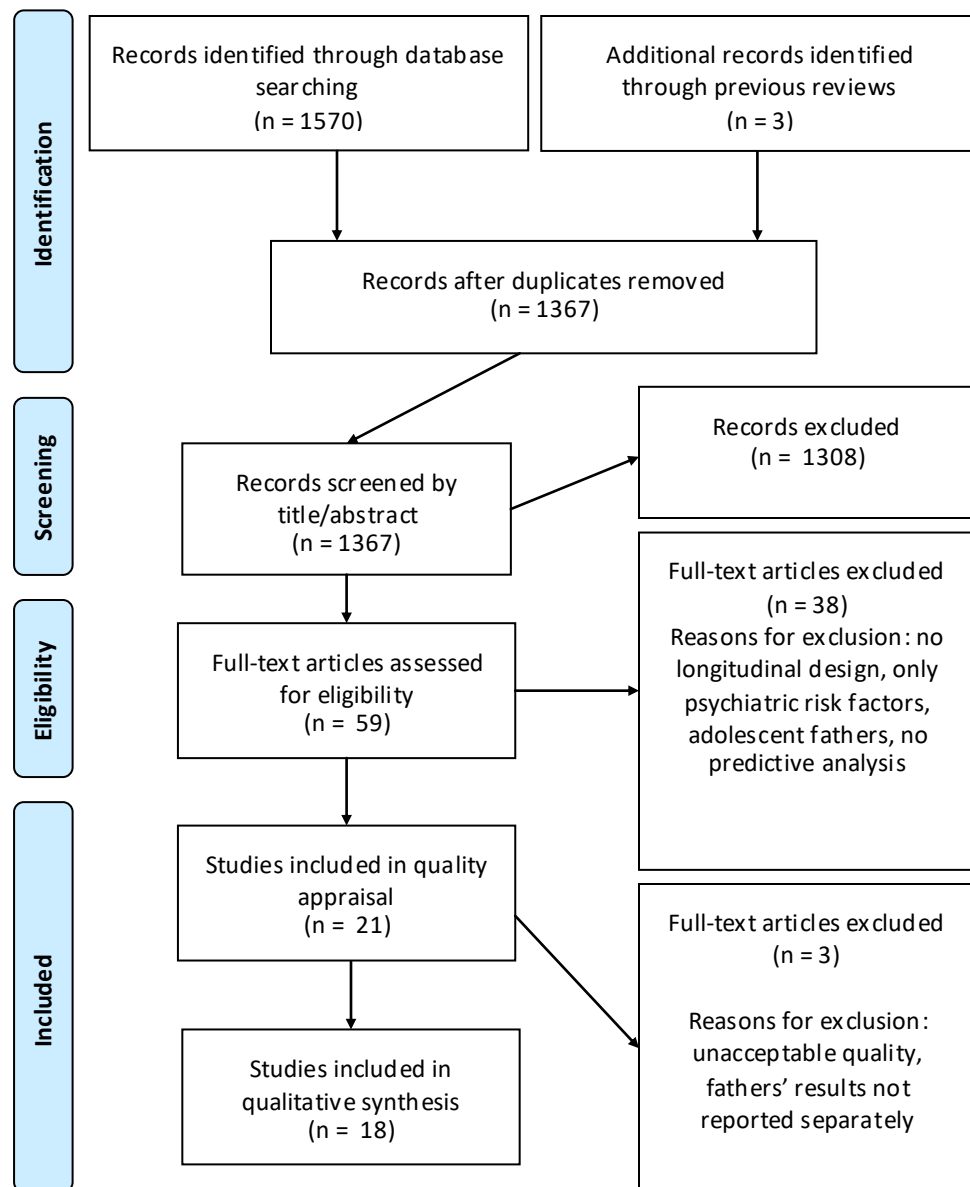


Figure 1.1: Flow diagram of literature search using the PRISMA flow diagram template (Moher et al., 2009).

### Quality Appraisal of Studies

Quality criteria were identified and adapted to the studies reviewed using the SIGN Methodology Checklist for cohort studies and the NICE “Quality appraisal checklist – quantitative studies reporting correlations and associations”. A total of 14 quality criteria were used, in addition to three overall ratings regarding reliability of the results and internal and external validity of the study. The quality criteria, associated ratings and number of studies for each rating are listed in Table 1.1. If a study received lowest ratings on all three overall ratings scores (15. Low Quality; 16. Unacceptable; 17. No/Can’t say), the study was excluded from the review based on the results being not interpretable (Meline, 2006). Of the 21 studies, two sets of six were rated by two independent raters (yielding an overall of 57% of studies that were rated independently). Interrater reliability (Krippendorff’s alpha, Hayes and Krippendorff, 2007) was calculated, but due to low number of comparisons, the percentage of agreement is also provided. Percentage of agreement, as opposed to Krippendorff’s alpha, is a somewhat unreliable measure as it does not take into account chance agreement between the raters. However, due to low number of comparisons and high interrater agreement, chance agreement is very high, lowering the interrater reliability artificially. We therefore propose to interpret interrater reliability with overall agreement and number of compared studies per rater in mind (Table 1.1). If differences between ratings were markedly different, these were discussed and consensus sought if possible. The first author made the final decision regarding scoring and inclusion.

Table 1.1: Overview of quality criteria ratings, number of studies for each rating and interrater reliability.

List of quality criteria and ratings	Number of studies for each rating (N = 21)	Interrater Reliability	
		% agreement, Krippendorff’s Alpha	
		Rater 1 (N = 6)	Rater 2 (N = 6)
1. The study addresses an appropriate and clearly focused question. (yes, no, can't say, does not apply)	Yes = 20 No = 0 Can't say = 1 Does not apply = 0	100%, n/d	83.3%, 0.476
2. The study indicates how many of the people asked to take part did so. (yes, no, can't say, does not apply)	Yes = 18 No = 2 Can't say = 1 Does not apply = 0	100%, 1.000	83.3%, 0.703
3. Baseline depressive symptoms are assessed and taken into account in the analysis. (yes, no, can't say, does not apply)	Yes = 18 No = 3 Can't say = 0 Does not apply = 0	100%, 1.000	100%, 1.000
4. Indicates percentage of individuals that dropped out before completion of the study (yes, no, can't say, does not apply)	Yes = 20 No = 0 Can't say = 1	100%, n/d	100%, 1.000

Table 1.1: Overview of quality criteria ratings, number of studies for each rating and interrater reliability. (continued)

List of quality criteria and ratings	Number of studies for each rating (N = 21)	Interrater Reliability % agreement, Krippendorff's Alpha	
		Rater 1 (N = 6)	Rater 2 (N = 6)
5. Comparison is made between full participants and those lost to follow up, by risk factor and/or demographics. (yes, no, can't say, does not apply)	Yes = 13 No = 4 Can't say = 1 Does not apply = 3	83.3%, 0.000	83.3%, 0.621
6. The outcomes are clearly defined (yes, no, can't say)	Yes = 21 No = 0 Can't say = 0	100%, n/d	100%, n/d
7. Were the outcome measures and procedures reliable? (yes, no, can't say)	Yes = 21 No = 0 Can't say = 0	100%, n/d	100%, n/d
8. The assessment of outcome is made blind to exposure status. (yes, no, can't say, does not apply)	Yes = 0 No = 0 Can't say = 1 Does not apply = 20	100%, n/d	100%, n/d
9. If blinding was impossible, it is recognised that this could have influenced the assessment of outcome. (yes, no, can't say)	Yes = 0 No = 0 Can't say = 1 Does not apply = 20	100%, n/d	100%, n/d
10. The method of assessment of risk factors is reliable and valid. (yes, no, can't say, partially)	Yes = 10 No = 1 Partially = 4 Can't say = 6 Does not apply = 0	83.3%, 0.756	66.7%, 0.500
11. Evidence for prior outcome measure validation and reliability (yes, no, can't say, does not apply)	Yes = 21 No = 0 Can't say = 0 Does not apply = 0	100%, n/d	83.3%, 0.000
12. Risk factors are assessed more than once. (yes, no, can't say, does not apply)	Yes = 16 No = 5 Can't say = 0 Does not apply = 0	100%, 1.000	83.3%, 0.593
13. The main potential confounders are identified and taken into account in the design and analysis. (yes, no, can't say)	Yes = 15 No = 5 Can't say = 1	83.3%, 0.593	83.3%, 0.686
14. Confidence intervals are provided. (yes, no)	Yes = 5 No = 16	100%, 1.000	100%, 1.000
15. Overall internal validity (High Quality, Acceptable, Low Quality)	High Quality = 3 Acceptable = 14 Low Quality = 4	83.3%, 0.756	83.3%, 0.686
16. Overall external validity (High Quality, Acceptable, Unacceptable)	High Quality = 5 Acceptable = 14 Unacceptable = 2	83.3%, 0.593	83.3%, 0.621
17. Reliability of results (yes, no, can't say)	Yes = 14 No = 2 Can't say = 5	83.3%, 0.593	83.3%, 0.766

Table 1.2: Overview of studies included in the review.

Study Authors and Year	Relevant Study Hypotheses/Research Questions	N	Population, recruitment source	Psychosocial Risk Factors and Measures	Depression measures	Time points	Key findings, incl. analysis, statistics, significance
1. Mickelson, K. D., Biehle, S. N., Chong, A., & Gordon, A. (2016)	1. Internalized PPD stigma will be related to greater PPD symptoms through lower levels of parenting efficacy 2. Experienced PPD stigma will be related to greater PPD symptoms through higher levels of indirect support-seeking from family and friends 3. fathers' internalized pathway will be stronger than their experienced pathway	92 fathers	Baby T.I.M.E. Study First-time, low-risk pregnancies, low-risk sample with respect to education and income, i.e. no recruitment from low-income neighborhoods	<b>Perceived Stigma:</b> 8 items adapted from Mickelson (2001) to measure (1) internalised stigma ( $\alpha=.61$ ) and (2) externalised stigma (T2: $\alpha=.64$ ).  <b>Support Seeking:</b> 5 items adapted from Williams and Mickelson (2008) (T2: 1-month: $\alpha=.81$ ; T3: 4-months: $\alpha=.76$ ).  <b>Parenting Efficacy:</b> Adapted Self-Efficacy for Parenting Tasks Index (Coleman and Karraker 2003), (T2: 1-month: $\alpha=.67$ ; T3: 4-months: $\alpha=.85$ )	prenatal: CES-D, $\alpha=.88$ , cut-off = 16  postnatal: Postpartum Depression Screening Scale (PDSS), 1-month: $\alpha=.86$ , 4-months: $\alpha=.81$	T1: third trimester T2: 1 month T3: 4 months	Multiple Regression Mediation Analysis 1. Direct effect: experienced stigma at 1-month postpartum did not significantly predict PPD symptoms at 4 months 2. Indirect effect: parenting efficacy at 4-months postpartum was a significant mediator between experienced stigma at 1-month postpartum and paternal PPD symptoms at 4-months postpartum ( $z=.72$ , $SE=.44$ , 95 % CI [.06, 1.88]). The more experienced stigma fathers felt at 1-month postpartum regarding their PPD symptoms, the less parenting efficacy they reported at 4-months postpartum, and, in turn, the more PPD symptoms they reported at 4-months postpartum. 3. Internalized stigma at 1-month postpartum showed no direct or indirect association with 4-month PPD symptoms.
2. Gross, C. L., & Marcussen, K. (2016)	1. Prenatal parenting efficacy will be negatively associated with depression in the postpartum periods for both mothers and fathers. 2. Unmet parenting efficacy expectations (i.e., the difference between expectations prior to birth and perceived efficacy after birth) will be associated with higher levels of PPD	75 fathers	Baby T.I.M.E. Study First-time, low-risk pregnancies, low-risk sample with respect to education and income, i.e. no recruitment from low-income neighborhoods	<b>Parenting Efficacy (expected/perceived/unmet expectations):</b> Adapted Self-Efficacy for Parenting Tasks (SEPTI-TS) (Coleman and Karraker 2003) $\alpha=.65$ during pregnancy, .78 at 1-month, and .71 at 4-months).	prenatal: CES-D, $\alpha=.88$ , cut-off = 16  postnatal: Postpartum Depression Screening Scale (PDSS), 1-month: $\alpha=.86$ , 4-months: $\alpha=.81$	T1: third trimester T2: 1 month T3: 4 months	Structural Equation Modelling (path model) 1. Prenatal expectations of parenting efficacy are a significant predictor of 1-month PPD for fathers ( $\beta = -.322$ , $p = .003$ ) 2. The greater the degree of unmet expectations between pregnancy and 1-month postpartum, the higher the levels of 1-month postpartum PPD ( $\beta = -.248$ , $p = .014$ ). 3. Prenatal parenting efficacy expectations remain a significant predictor of PPD at 4-months postpartum for fathers ( $\beta = -.280$ , $p = .019$ ). 4. Increases in negative parenting efficacy experiences at 4-months postpartum relative to prenatal efficacy expectations were associated with higher levels of PPD in fathers ( $\beta = -.213$ , $p = .048$ ). The higher the levels of expected parenting efficacy during pregnancy the lower the levels of depression reported at 1 and 4 months postpartum. Fathers whose efficacy experiences were more negative than their prenatal expectations reported higher levels of PPD.

Table 1.2: Overview of studies included in the review (continued).

Study Authors and Year	Relevant Study Hypotheses/Research Questions	N	Population, recruitment source	Psychosocial Risk Factors and Measures	Depression measures	Time points	Key findings, incl. analysis, statistics, significance
3. Ngai, F.-W., & Ngu, S.-F. (2015)	1. The predictive role on PPD in fathers of family sense of coherence, stress, social support, and family and marital functioning during pregnancy. 2. The effect of changes from pre- to postpartum of any of these variables have on PPD.	256 fathers	Childbearing couples aged 18 or above, antenatal clinic of a regional hospital in Hong Kong, able to read Chinese and having no previous history of psychiatric illness. Most had secondary level of education and full-time jobs. Most of them first-time parents, but also multiparous. mostly middle-class.	<b>Family Sense of Coherence:</b> Family Sense of Coherence Scale Short Form (FSOC-S, validated Chinese version). $\alpha=.83$ , test-retest reliability .75. Construct validity was demonstrated. The internal consistencies in the present study ranged from .80 to .90.  <b>Psychological distress, Social Support, Family and Marital Functioning:</b> Social Readjustment Rating Scale (SRRS, modified Chinese version): $\alpha=.72-.82$ .  <b>Medical Outcomes Study Social Support Survey (MOS-SSS, validated Chinese version):</b> $\alpha=.98$ , test-retest reliability .84. Construct validity demonstrated. $\alpha=.96-.97$ .  <b>Medical Outcomes Study Family and Marital Functioning Measures (MOS-FMFM, validated Chinese version):</b> $\alpha=.79$ , test-retest reliability .74. Construct validity demonstrated. $\alpha=.70-.76$ .	GHQ (General Health Questionnaire) - chinese version: sensitivity of 88% and specificity of 89% using a cutoff score of 4/5. Concurrent validity with BDI and EPDS. The internal consistencies in the present study ranged from .74 to .83.	T1: during pregnancy T2: 6 months	Multiple Regression Analysis Weak sense of family sense of coherence ( $\beta = -.30$ , $p < 0.01$ ) and changes in family sense of coherence from pregnancy to 6 months postpartum ( $\beta = .38$ , $p < .01$ ) were significant predictors of depressive symptoms at 6 months postpartum.
4. Karukivi, M., Tolvanen, M., Karlsson, H., & Karlsson, L. (2015)	1. Are alexithymic features during pregnancy a risk factor for postpartum depression and anxiety?	65 fathers	sample from FinnBrain Birth Cohort Pilot study	<b>Alexithymia:</b> Toronto Alexithymia Scale (TAS-20). Psychometrically validated.	EPDS (cut-off $\geq 10$ )	T1: prenatal T2: 3 weeks T3: 12 months	Linear Regression Analysis Alexithymic features at baseline do not predict depressive symptoms postpartum in fathers.

Table 1.2: Overview of studies included in the review (continued).

Study Authors and Year	Relevant Study Hypotheses/Research Questions	N	Population, recruitment source	Psychosocial Risk Factors and Measures	Depression measures	Time points	Key findings, incl. analysis, statistics, significance
5. Gawlik, S., Müller, M., Hoffmann, L., Dienes, A., Wallwiener, M., Sohn, C., .... Reck, C. (2014)	1. Prenatal partnership quality, birth-related anxiety, and concerns about the future predict paternal postnatal depressive symptoms.	102 fathers	relatively high level of education, no migration background	<b>Partnership Satisfaction:</b> Questionnaire of Partnership (PFB; Hahlweg 1996): Cronbach's $\alpha = .88-.93$ , 6-month test-retest reliability $r = .68-.83$ .  <b>Birth and future concerns:</b> self-constructed questionnaire	EPDS (cut-off $\geq 9$ )	T1: prenatal T2: 4-6 weeks	Stepwise Linear Regression Analysis Prenatal EPDS scores, birth concerns, and the partnership satisfaction predicted 47% of the variance in paternal postnatal depressiveness. After applying robust estimation of regression on postnatal depressiveness, birth concerns ( $B = 0.09$ , $CI[0.02-0.16]$ , Wald $\chi^2 = 5.66$ , $p < .05$ ) and relationship quality ( $B = -0.06$ , $CI[-0.10-0.01]$ , Wald $\chi^2 = 6.16$ , $p < .05$ ) revealed to be even more important than prenatal EPDS scores.
6. Escribá-Aguir, V., & Artazcoz, L. (2011)	1. To determine gender differences between women and their partners in the effect of psychosocial (marital dissatisfaction, social support) and personal (history of depression, negative life events, pregnancy depression and partner's depression) factors on depression during the first year postpartum.	669 fathers	community primary care, Valencia	<b>Marital Satisfaction:</b> ENRICH Marital Satisfaction Scale (translated): Cronbach's $\alpha = .93$ .  <b>Social Support:</b> Duke-UNC Functional Social Support Questionnaire (11 items, validated for Spain, Broadhead, Gehlbach, De Gruy, & Kaplan, 1988): affective social support scale $\alpha = .79$ , functional/confidant social support scale $\alpha = .88$ .	EPDS (cut-off $\geq 11$ )	T1: third trimester T2: 3 months T3: 12 months	Logistic Regression Analysis (generalised estimating equation) Only low marital satisfaction increased the probability of PPD symptoms significantly ( $OR = 2.23$ , $CI[1.05-4.75]$ , $p < .05$ ).
7. Castle, H., Slade, P., Barranco-Wadlow, M., & Rogers, M. (2008)	1. Antenatal depression scores, attitudes towards emotional expression and perceived social support will predict postnatal depression and well-being scores.	66 fathers	antenatal classes, Yorkshire, UK 18 years or older, married or cohabiting, and with sufficient use of the English language, predominantly white middle-class couples	<b>Attitudes towards Emotional Expression (AEE)</b> (Joseph, Williams, Irwing, & Cammock, 1994): Cronbach's $\alpha = .79$ in this study, previous studies: $\alpha = .77-.90$ .  <b>Social Support:</b> DUKE-UNC Functional Social Support Questionnaire (FSSQ): test-retest reliability $r = .66$ , Confidant subscale $\alpha = .62$ and Affective subscale $\alpha = .64$ .	Prenatal: HADS Well-being Questionnaire (WBQ) (Bradley & Lewis, 1990) (includes depression, anxiety and well-being): no psychometrics provided Postnatal: EPDS (continuous)	T1: third trimester T2: 6 weeks	Sequential Multiple Regression Analysis Prenatal distress (using HADS total score as the EPDS was not administered in the prepartum) accounted 24.8% for fathers. Confidant (functional) social support added significantly to the predictive capacity for general distress (HADS total and depression) after accounting for prenatal levels of distress. (HADS depression: $t = 5.1$ , $p < .001$ , $R^2 = .289$ ?)

Table 1.2: Overview of studies included in the review (continued).

Study Authors and Year	Relevant Study Hypotheses/Research Questions	N	Population, recruitment source	Psychosocial Risk Factors and Measures	Depression measures	Time points	Key findings, incl. analysis, statistics, significance
8. Bradley, R., Slade, P., & Leviston, A. (2008)	1. To provide comparison of risk factors for PTSD with the prevalence and predictors for symptoms of depression and anxiety.	199 fathers	fathers of babies delivered in hospital	<b>Perception of Labour and Delivery:</b> Perception of Labour and Delivery Scale (PLDS) (Czarnocka & Slade, 2000) <b>Perceived Control during Labour and Delivery:</b> Perceived Control Scale (PCS) (Wallston, 1989), adapted for fathers No psychometric properties provided.	EPDS (cut-off $\geq 10$ )	T1: 72h after birth T2: 2 weeks	Stepwise Linear Regression Higher levels of depressive symptoms were predicted by lower confidence about coping ( $R^2 = .755$ , $\beta = -0.32$ , $p < .01$ ) and a higher worst fear for partner during labour and delivery ( $R^2 = .760$ , $\beta = 0.22$ , $p < .05$ ).
9. Hall, W. A., & Long, B. C. (2007)	1. Role quality as the quantity and quality of time and energy spent in paid work, family, and individual domains, and expected prenatal role quality to be associated with PPD 2. Prenatal role conflict, a dimension of role quality, would be associated with dual-earners' PPD 3. Greater prenatal role disparity in family, work, and individual domains and intensity of demands would predict greater PPD 4. Greater prenatal life satisfaction (confounding variable), as well as greater role quality, would be associated with less PPD	99 couples	prenatal classes, work sites, newsletters, newspapers, fitness centers, and ultrasound departments, mostly middle class	<b>Prenatal Work-Family Strain:</b> Work-Family Strains Scale (WFSS): Validity demonstrated, Cronbach's $\alpha = .80$ . <b>Role Disparity and Intensity:</b> Role Enactment Questionnaire (Hall, 1993): Cronbach's $\alpha = .89$ on the intensity dimension and $\alpha = .90$ on the disparity dimension. Test-retest reliability $r = .80$ for intensity and $r = .73$ for disparity. <b>Prenatal Life Satisfaction:</b> Satisfaction with Life Scale (SWLS): test-retest reliability $r = .82$ , Cronbach's $\alpha = .86$ .	CES-D (cut-off $> 16$ )	T1: prenatal 16-40 weeks T2: 4-28 weeks	Hierarchical Multiple Regression Analysis Role intensity ( $\beta = .15$ ), role disparity ( $\beta = .16$ ), and life satisfaction ( $\beta = -0.14$ ) accounted for an additional 5% of the variance in postpartum depression ( $\Delta R^2 = .05$ , $p = .004$ ), while controlling for prenatal depression, age, and gender. Work-family role strain did not independently account for a significant amount of variance in postnatal depression.



Table 1.2: Overview of studies included in the review (continued).

Study Authors and Year	Relevant Study Hypotheses/Research Questions	N	Population, recruitment source	Psychosocial Risk Factors and Measures	Depression measures	Time points	Key findings, incl. analysis, statistics, significance
10. Huang, C.-C., & Warner, L. (2005)	1. The likelihood that a father will experience a major depressive episode within a year of his child's birth is assumed to be dependent on the status and quality of the relationship that he has with the mother of the child.	3367 fathers	Fragile Families and Child Well-Being Survey (FFCWS)	<b>Disagreement about pregnancy:</b> one item  <b>Maternal Supportiveness:</b> four items, Cronbach's $\alpha = .62$ .	T1: CES-D (T1) T2: CIDI-SF (Walters et al., 2002) (spanning 1 year postpartum period)	T1: as soon as possible after birth T2: 12 months after baseline	Logistic Regression Analysis With the addition of depressive symptoms at baseline, maternal supportiveness is no longer a statistically significant predictor of paternal PPD. Disagreement about the pregnancy significantly predicts fathers' depression at year 1 (OR = .28, SE = .15, $p < .05$ ).
11. Edhborg, M., Matthiesen, A., Lundh, W., & Widstrom, A. (2005)	1. Early circumstances, such as previous depressive symptoms, negative life events during the last year, mode of delivery, breastfeeding, parental blues, bonding and the parents' perception of their child's temperament predict postpartum depressive symptoms.	106 fathers	maternity ward	<b>Infant Bonding:</b> Postpartum Bonding Questionnaire (PBQ; Brockington et al., 2001; Swedish translation), no psychometrics provided, but reliability and validity established in other studies (not subscale risk of abuse).	T1: The Blues Questionnaire; Kennerly & Gath, 1987: reliability and validity established in other studies  T2: EPDS (cut-off 9/10)	T1: right after birth to 1 week T2: 2 months	Regression Analysis Less impaired bonding at 1 week is associated with higher depressive symptoms at 2 months ( $\beta = -.167$ , $t = -2.554$ , $p = 0.012$ ), but cross-sectionally, more impaired bonding at 2 months is associated with more depressive symptoms ( $\beta = .244$ , $t = 3.890$ , $p < 0.0002$ ).

Table 1.2: Overview of studies included in the review (continued).

Study Authors and Year	Relevant Study Hypotheses/Research Questions	N	Population, recruitment source	Psychosocial Risk Factors and Measures	Depression measures	Time points	Key findings, incl. analysis, statistics, significance
12. Morse, C. A., Buist, A., & Durkin, S. (2000)	1. To explore risk factors for major or minor depression, to examine the influences that shape and determine the couple's experiences, from each partner's perspective.	251 fathers	public antenatal clinics, Shared Care programs (combined midwife and general practitioner) and Birth Centre (midwife-managed care)	<p><b>Relationship Functioning:</b> Short Form of the Spanier Dyadic Adjustment Scale (<math>\alpha = .90</math>) Intimate Bonds Questionnaire (<math>\alpha = .89-.94</math>. Test-retest reliability <math>r = .80-.89</math>.)</p> <p><b>Social Support:</b> Social Support Questionnaire (self-constructed adapted version), no psychometrics provided</p> <p><b>Gender Role Stress:</b> Masculine and Feminine Gender Role Stress Scale (<math>\alpha = .79</math>, test-retest reliability <math>r = .82</math>.)</p>	<p>EPDS (cut-off <math>\geq 10</math>)</p> <p>Depression Inventory Short Form (internal consistency with long form <math>\alpha = .89</math>), excluding somatic symptoms</p>	<p>T1: 24 weeks gestation</p> <p>T2: 36 weeks gestation</p> <p>T3: 1 month</p> <p>T4: 4 months</p>	<p>Hierarchical Logistic Regression Analysis</p> <p>A high perceived sense of being controlled in the marital relationship during pregnancy (<math>B=0.173</math>, <math>SE B = 0.059</math>, <math>p &lt; 0.01</math>) was the only psychosocial risk factor for PPD symptoms in men at either 1 or 4 months postpartum.</p>
13. Matthey, S., Barnett, B., Ungerer, J., & Waters, B. (2000)	1. The impact of partner support, relationship with own parents, interpersonal sensitivity, personality on mothers' and fathers' depressive symptoms postnatally	157 fathers	The educational level of the sample varied broadly	<p><b>Partner Support:</b> Intimate Bonds Questionnaire (<math>\alpha = .89-.94</math>. Test-retest reliability <math>r = .80-.89</math>; concurrent validity with interviewer ratings: <math>.68-.74</math>) Parental Bonding Instrument (PBI): test-retest reliability <math>r = .63-.76</math>; split-half reliability: <math>.74-.88</math>; concurrent validity with interviewer ratings: <math>.51-.78</math>.</p> <p><b>Interpersonal Sensitivity:</b> Interpersonal Sensitivity Measure (IPSM) (Boyce and Parker, 1989) Cronbach's <math>\alpha = .86</math> (subscales from <math>.55</math> to <math>.79</math>), test-retest reliability <math>r = .7</math> (subscales from <math>.55</math> to <math>.77</math>). concurrent validity with interviewer ratings: <math>.72</math>)</p> <p><b>Personality:</b> Eysenck Personality Inventory</p>	<p>BDI <math>&gt; 9</math> (and <math>&gt; 16</math> as control for normal symptoms of pregnancy)</p> <p>GHQ</p>	<p>T1: prenatal</p> <p>20-24 weeks</p> <p>T2: 6 weeks</p> <p>T3: 16 weeks</p> <p>T4: 52 weeks</p>	<p>Step-wise Multiple Regression Analysis</p> <p>At 18 weeks, risk factor for men's depressed mood were a high neuroticism score (<math>\beta = 0.18</math>) and high partner control (<math>\beta = 0.17</math>) (adjusted <math>R^2 = 0.40</math>). No significance level provided.</p>

Table 1.2: Overview of studies included in the review (continued).

Study Authors and Year	Relevant Study Hypotheses/Research Questions	N	Population, recruitment source	Psychosocial Risk Factors and Measures	Depression measures	Time points	Key findings, incl. analysis, statistics, significance
14. Leathers, S. J., & Kelley, M. A. (2000)	1. Men and women's perceptions of pregnancy intendedness do not always correspond, each partner's assessment of intention has a distinct effect on PDS. 2. Quality of couple's relationship and adequacy of support as moderators of associations between PDS and unintended pregnancy.	124 fathers	The sample obtained was racially heterogeneous and well educated	<b>Pregnancy Intendedness:</b> modified item from the National Survey of Family Growth (Kaufmann, Morris, & Spitz, 1997) on pregnancy intendedness (face validity)  <b>Relationship distress:</b> Measured using a 7-item scale consisting of three items developed by Ross (1995) and four developed specifically for the current study (Cronbach's $\alpha = .70-.76$ ).  <b>Social Support:</b> 3 self-constructed items of social support, summed into index. Cronbach's $\alpha = .67$ .	CES-D (without pregnancy confounded items), Cronbach's $\alpha = .82$ during pregnancy and $\alpha = .71$ at four months postpartum, which compares favorably with other studies using a reduced item scale	T1: 2-3 months before birth T2: 3-4.5 months after birth	Hierarchical Ordinary Least-squares Regression Analysis Unintended pregnancy and relationship distress were marginally significant predictors of postpartum depressive symptoms, with relationship distress explaining only 1 % of the variance of the effect of pregnancy unintendedness and depressive symptoms. Need for support was not significant.
15. Soliday, E., McCluskey-Fawcett, K., & O'Brien, M. (1999)	What are predictors of post-partum affect (marital adjustment, parenting stress, coping)	51 fathers	antenatal classes, GPs	<b>Marital Adjustment:</b> Dyadic Adjustment Scale short form (Sharpley and Cross, 1982), Cronbach's $\alpha = .96$ .  <b>Parenting Stress:</b> Parenting Stress Index short form (Abidin, 1995), Cronbach's $\alpha = .91$  <b>Coping:</b> COPE (Carver, Sheier, Weintraub, 1989)  For all scales, internal consistencies within the study were above $\alpha = .70$ .	CES-D (cut-off > 16)	T1: prenatal T2: 4-6 weeks	Hierarchical Multiple Regression Analysis High prepartum parenting stress predicted 14.1% of postpartum CES-D ( $R^2 = .14$ , $F = 9.66$ , $\beta = .44$ , $p < .005$ ).

Table 1.2: Overview of studies included in the review (continued).

Study Authors and Year	Relevant Study Hypotheses/Research Questions	N	Population, recruitment source	Psychosocial Risk Factors and Measures	Depression measures	Time points	Key findings, incl. analysis, statistics, significance
16. Deater-Deckard, K., Pickering, K., Dunn, J. F., & Golding, J. (1998).	1. to explore the role of several mediating factors that have been emphasized in past research, including stressful life events, social and emotional support, the quality of the partner relationship, and socioeconomic circumstances	7018 fathers	Avon Longitudinal Study of Pregnancy and Childhood	<b>Social Support and Social Network:</b> Self-constructed questionnaires for social support and network ( $\alpha = .69$ and $.75$ respectively)  <b>Relationship quality:</b> two self-constructed scales (aggression $\alpha = .82$ , lack of affection $\alpha = .84$ )	EPDS (continuous for analysis)	T1: 18 weeks prenatal T2: 8 weeks post-partum	Regression Analysis A higher postpartum depression score was associated with receiving less social support ( $\beta = .08$ , $SE = .01$ , $CI [-.11 \text{ } -.06]$ , $p < .001$ ), having smaller social networks ( $\beta = -.04$ , $SE = .01$ , $CI [-.06 \text{ } -.01]$ , $p < .01$ ), and having more aggressive ( $\beta = -.14$ , $SE = .03$ , $CI [-.19 \text{ } -.08]$ ) and less affectionate ( $\beta = -.08$ , $SE = .01$ , $CI [.05 \text{ } .11]$ , $p < .001$ ) partner relationships.
17. Areias, M., Kumar, R., Barros, H., & Figueiredo, E. (1996b)	1. We compare and contrast some of the correlates of paternal and maternal depression after the live birth of a first child (exploratory)	42 fathers	antenatal clinics in Oporto, Portugal	<b>Social Adjustment:</b> Social Adjustment Scale (SAS, Weissman & Paykel, 1974). No psychometrics provided.  <b>Personality:</b> Eysenck Personality Inventory (Eysenck & Eysenck, 1964)	SADS, semi-structured interview (at T1 and T3) EPDS	T1: 6 months gestation T2: 3 months (subset) T3: 12 months	Logistic Regression Analysis No psychosocial risk factors we included in the regression model despite exploratory correlations indicating that poor social adjustment both during pregnancy and after childbirth may be associated with higher PDS.

Table 1.2: Overview of studies included in the review (continued).

Study Authors and Year	Relevant Study Hypotheses/Research Questions	N	Population, recruitment source	Psychosocial Risk Factors and Measures	Depression measures	Time points	Key findings, incl. analysis, statistics, significance
18. Atkinson, A. K., & Rickel, A. U. (1984)	1. The experience of disruption related to the new demands of child care and the degree to which fathers experienced depression postpartum.	78 fathers	middle socioeconomic status (SES), married, recruited through private physicians and childbirth preparation classes	<p><b>Amount of time spent in infant caretaking:</b> Self-designed Inventory of Caregiving Behavior (ICB): Cronbach's <math>\alpha = .78</math> (pre) and <math>\alpha = .80</math> (post).</p> <p><b>Extent to which infant behaviour is viewed as problematic/bothersome:</b> The Neonatal Perception Inventory (NPI): test-retest reliability <math>r = .82</math>. Degree of Bother Inventory: test-retest reliability <math>r = .86</math>. (both instruments by Broussard &amp; Hartner, 1971).</p> <p><b>Frequency and Enjoyability of reinforcing events:</b> The Pleasant Events Schedule-mood-related scale (PES-MR scale; MacPhillamy &amp; Lewinsohn, 1976) test-retest at 1 month, <math>r = .59</math>; at 2 months, <math>r = .50</math>.</p>	BDI (standardised cut-off)	T1: 8 weeks before birth T2: 8 weeks	Multiple Regression Analysis The results suggest that fathers who expect prior to the birth of the infant that their infant will be better than the average newborn ( $\beta = -.29$ , $p < .01$ ); and after the birth, view the infant as below average ( $\beta = .20$ , $p < .05$ ) are most likely to experience postpartum depression.

### 1.3 Findings

Twenty-one studies met the a priori inclusion/exclusion criteria for the review. Of these, three were rated as having high quality internal validity, five as having high quality external validity and 14 were deemed to have reliable results (Table 1.1). Fourteen studies had acceptable internal validity and 14 acceptable external validity. Only five studies reported confidence intervals. Two studies were rated as having unacceptable reliability, external validity and internal validity and were therefore excluded from the review based on their low quality (Kerstis et al., 2012; Roubinov et al., 2014). In addition, even though initially meeting the inclusion criteria for this review, one further study was excluded (Johnson and Baker, 2004). Despite acceptable quality, Johnson and Baker did not report results separately for fathers who had had live births. Instead results of fathers with healthy infants were indistinguishable from results of fathers whose partners had had a miscarriage and could therefore not be interpreted. Hence, the following synthesis was based on the remaining 18 studies, which are listed in Table 1.2. The psychosocial risk factors examined in these studies were categorised into six broad areas: father -infant bonding, birth concerns, parenting-related risk factors, social support variables, marital/partner/family variables, and individual variables. All included studies, their quality ratings and studied risk factors are listed by category in Table 1.3.

#### *Father-Infant Bonding*

Only one study addressed the impact of father-infant bonding at one week and two months on depressive symptoms at two months postpartum (Edhborg et al., 2005). They found that less impaired bonding at one week was associated with higher depressive symptoms at two months ( $\beta = -0.167$ ,  $t = -2.554$ ,  $p < .05$ ), but cross-sectionally more impaired bonding at two months was associated with more depressive symptoms ( $\beta = 0.244$ ,  $t = 3.890$ ,  $p < 0.01$ ). The study authors speculated that this unexpected result could reflect recovery from early bonding difficulties in some fathers, and increased bonding difficulties in other fathers at two months.

#### *Birth Concerns*

This category included concerns about the birth and future with a child as well as the experience of labour and delivery. Gawlik et al. (2014) entered prenatal concerns about the birth into a model with postpartum depressive symptoms as well as relationship satisfaction and found that birth concerns (and relationship satisfaction) had more predictive value than prenatal depressive symptoms (birth concerns:  $B = .09$ ,  $CI [.02 .16]$ , Wald  $\chi^2 = 5.66$ ,  $p < .05$ ), while future concerns were not significant in this model. Bradley et al. (2008) found a significant predictive effect of high fear for partner during childbirth on postpartum

depressive symptoms in fathers ( $\beta = .22, p < .05$ ), but not for perceived control during labour. This study included a large number of participants (199 fathers), but had serious qualitative flaws regarding the measurement of risk factors and depression, which reduced its internal validity rating.

#### *Parenting Related Risk Factors*

This category comprised the experience of disruption from new demands of caretaking and associated expectations, parenting efficacy and parenting stress. Atkinson and Rickel (1984) examined the perceived disruption due to the new demands of caretaking, especially when demands did not meet experiences. They found that PDS were most strongly related to viewing the infant's behavior less positively postpartum ( $\beta = .20, p < .05$ ) and more positively (expected) prepartum ( $\beta = -.29, p < .01$ ) with higher levels of experienced pleasant events prepartum ( $\beta = .23, p < .05$ ), indicating that disconfirmed expectations of the demands of caretaking led to more depressive symptoms postpartum. In this study, confounding variables (other than prenatal depression) were not taken into account, and no drop-out analysis was provided. Gross and Marcussen (2016) studied expected and experienced parenting efficacy as well as their discrepancy as a predictor for PPD. They found that the higher the levels of expected parenting efficacy during pregnancy, the lower the levels of depression reported at one ( $\beta = -.322, p < .01$ ) and four months postpartum ( $\beta = -.280, p < .05$ ). Fathers whose efficacy experiences at one ( $\beta = -.248, p < .05$ ) and four months ( $\beta = -.213, p < .05$ ) were more negative than their prenatal expectations, reported higher levels of PPD. In the same sample, Mickelson et al. (2016) looked at the perceived stigma of having PPD at one month postpartum and its effect on PPD at four months. They found that perceived stigma did not directly influence PPD symptoms at four months, but only did so through the mediator variable parenting efficacy ( $z = .72, SE = .44, CI [.06 1.88]$ ).

Table 1.3: Overview of quality ratings for studies sorted by category.

Study	Risk factors, significance	Internal validity	External validity	Reliability
<b>Infant variables</b>				
Edhborgh et al. 2005	Less impaired infant bonding*	Acceptable (+)	Acceptable (+)	yes
<b>Birth variables</b>				
Bradley et al. 2008	High fear for partner during childbirth* Perceived control during labour	Low Quality (0)	Acceptable (+)	yes
Gawlik et al. 2014	Concerns about birth* Concerns about future	High Quality (++)	Acceptable (+)	Yes
<b>Parenting variables</b>				
Mickelson et al. 2016	Perceived stigma Parenting efficacy as mediator between perceived stigma and PPD*	Acceptable (+)	Acceptable (+)	yes
Gross et al. 2016	Lower expected parenting efficacy* Higher expected and lower experienced parenting efficacy*	Acceptable (+)	Acceptable (+)	yes
Atkinson & Rickel 1984	Viewing the infant's behavior less positively postpartum* Viewing infant's behaviour more positively (expected) prepartum* Higher levels of experienced pleasant events prepartum*	Acceptable (+)	Acceptable (+)	yes
<b>Support variables</b>				
Mickelson et al. 2016	Support seeking	Acceptable (+)	Acceptable (+)	yes
Ngai & Ngu 2015	Social support Change in social support from prenatal to postnatal period	Acceptable (+)	Acceptable (+)	yes
Escriba-Aguir & Artazcoz 2011	Confidant support Emotional support	High Quality (++)	High Quality (++)	yes
Castle et al. 2008	Low confidant support* Emotional support	Acceptable (+)	Acceptable (+)	can't say
Huang & Warner 2005	Mother's supportiveness at birth	Acceptable (+)	High Quality (++)	yes
Matthey et al. 2000	High partner control (= low partner support)* (no significance level provided)	Acceptable (+)	High Quality (++)	yes
Morse et al. 2000	High partner control* Support (partner, family, friends, confidant or emotional)	Acceptable (+)	Acceptable (+)	yes
Leathers & Kelley 2000	Social support	Acceptable (+)	Acceptable (+)	no
Deater-Deckard et al. 1998	Low social support* Smaller social network*	Acceptable (+)	High Quality (++)	yes

\* significant at  $p < .05$  or more



Table 1.3: Overview of quality ratings for studies sorted by category. (continued)

Study	Risk factors, significance	Internal validity	External validity	Reliability
<b>Marital/partner/family variables</b>				
Gawlik et al. 2014	Poor relationship quality*	High Quality (++)	Acceptable (+)	yes
Ngai & Ngu 2015	Low family sense of coherence* Change in family sense of coherence from prenatal to postnatal period* Family and marital functioning	Acceptable (+)	Acceptable (+)	yes
Escriba-Aguir & Artazcoz 2011	Low marital satisfaction*	High Quality (++)	High Quality (++)	yes
Huang & Warner 2005	Disagreement about pregnancy intendedness*	Acceptable (+)	High Quality (++)	yes
Soliday et al. 1999	Relationship adjustment	Acceptable (+)	Acceptable (+)	yes
Leathers & Kelley 2000	Own and partner's perceptions of intendedness of the pregnancy	Acceptable (+)	Acceptable (+)	no
Deater-Deckard et al. 1998	More aggressive partner relationship* Less affectionate partner relationship*	Acceptable (+)	High Quality (++)	yes
<b>Individual variables</b>				
Karukivi et al. 2015	Alexithymia	Acceptable (+)	Acceptable (+)	can't say
Morse et al. 2000	Gender role stress	Acceptable (+)	Acceptable (+)	yes
Matthey et al. 2000	High neuroticism* (no significance level provided) Interpersonal sensitivity	Acceptable (+)	High Quality (++)	yes
Castle et al. 2008	Attitudes towards emotional expression	Acceptable (+)	High Quality (++) Acceptable (+)	yes can't say
Hall & Long 2007	High role intensity* High role disparity* Low life satisfaction* Work-family strain	High Quality (++)	High Quality (++)	yes
Soliday et al. 1999	Coping style Prenatal parental stress*	Acceptable (+)	Acceptable (+)	yes
Areias et al. 1996	Neuroticism	Low Quality (0)	Acceptable (+)	can't say

\* significant at  $p < .05$  or more

### *Social Support Variables*

Social support was one of the most studied areas in paternal PDS/PPD and included variables such as social network, perceived support and support seeking. Only four studies found some predictive value in social support measures. Deater-Deckard et al. (1998) found that a higher postpartum depression score at eight weeks postpartum was associated with receiving less social support ( $\beta = .08$ ,  $CI[-.11 \text{ } -.06]$ ,  $p < .001$ ) and having smaller social networks ( $\beta = -.04$ ,  $CI[-.06 \text{ } -.01]$ ,  $p < .01$ ) at 18 weeks gestation. This study included a very large number of participants ( $n = 7018$  fathers) and despite self-constructed items to measure

these constructs, was rated to have acceptable internal and high external validity with reliable results. Similarly Castle et al. (2008) found that reported confidant social support in the third trimester of pregnancy had significant predictive capacity of PDS as measured by the HADS ( $t = 5.1, p < .001$ ), but not the EPDS. Matthey et al. (2000) found high partner control (measured as the opposite of partner support) a significant predictor of PDS in fathers at four months postpartum ( $\beta = .17$ , no significance level specified).

While Morse et al. (2000) also found that the perceived sense of being controlled in a relationship ( $B = .173, SE = .059, p < .01$ ) predicted postpartum depressive symptoms, they did not find any type of prenatal social support (partner, family, friends, instrumental or emotional) to be a significant predictor of PDS at either one or four months postnatally.

Similarly, Huang and Warner (2005) did not find the mother's supportiveness at birth to be a significant predictor of paternal depressive symptoms within the first postpartum year. While Morse et al. (2000) used a validated measure of social support, Huang et al. (2005) used four self-constructed items with only moderate internal consistency ( $\alpha = .62$ ), questioning the validity of their finding. Equally, Leathers and Kelley (2000) used a self-constructed scale of social support and did not find social support to be a significant risk factor. High quality evidence for lack of social support as a predictor of paternal PDS comes from Escriba-Aguir & Artazcoz (2011), who did not find predictive capacity of either prenatal emotional or confidant social support for postpartum depressive symptoms at either three or 12 months. Equally, Ngai and Ngu (2015) did not find a significant predictive effect of either prenatal social support or change of social support from prenatal to six months postpartum on postpartum depressive symptoms at six months. Finally, Mickelson et al. (2016) found no longitudinal predictive effect of support seeking, but only a cross-sectional effect instead.

#### *Marital/Partner/Family Variables*

This category included family sense of coherence, family and marital functioning, marital satisfaction, partnership adjustment, and pregnancy intendedness. Poor prenatal family sense of coherence ( $\beta = -.30, p < .01$ ) and change in family sense of coherence from pregnancy to six months postpartum ( $\beta = .38, p < .01$ ) were significant predictors of depressive symptoms at six months postpartum, but not family and marital functioning (Ngai and Ngu, 2015).

Gawlik et al. (2014) found that father-rated relationship quality ( $B = -.06, CI[-.10 -.01]$ , Wald  $\chi^2 = 6.16, p < .05$ ) was even more important in predicting PPD at four to six weeks than prenatal depressive symptoms. Escriba-Aguir and Artazcoz (2011) also reported a significant relationship between low marital satisfaction and increased risk of developing PDS ( $OR = 2.23, CI[1.05 4.75], p < .05$ ). Deater-Deckard et al. (1998) found that more aggressive ( $\beta = -.14, SE = .03, CI[-.19 -.08]$ ) and less affectionate ( $\beta = -.08, SE = .01, CI[.05 .11], p < .001$ ) partner relationships were a significant risk factor for depressive

symptoms at eight weeks postpartum. All three studies had acceptable to high quality ratings, suggesting that relationship difficulties can promote PPD/PDS, while high family sense of coherence can be protective. However, relationship adjustment, a gross measure of cohesion, agreement and satisfaction in a relationship, was not a significant predictor of depressive symptoms (Soliday et al., 1999).

Huang and Warner (2005) reported that disagreement between partners about pregnancy intendedness significantly predicted postpartum depressive symptoms ( $OR = .28$ ,  $SE = .15$ ,  $p < .05$ ). Own and partner's perceptions of intendedness of the pregnancy and relationship distress were not significant in Leathers' and Kelley's study (2000), however, they used self-constructed, non-validated items to measure these variables, so the validity of this result is unclear.

### *Individual Variables*

This category summarised individual variables like role disparity and intensity, prenatal life satisfaction, personality traits, social adjustment, alexithymic traits/attitudes towards emotional expression, coping styles, personal and gender role stress and work-family role strain. Matthey et al. (2000) reported that interpersonal sensitivity (similar to neuroticism), a measure of interpersonal awareness, need for approval, separation anxiety, timidity, and fragile inner-self, was not a significant predictor of depressive symptoms in fathers at four months postpartum, but a high neuroticism score was ( $\beta = .18$ , no significance level provided). Only one other study with low internal validity and unclear reliability studied neuroticism and found no significant effect (Areias et al., 1996).

Karukivi et al. (2015), rated as having acceptable validity, did not find that alexithymic features during pregnancy predicted postpartum depressive symptoms. However, their attrition rate was high, so it is difficult to estimate the reliability of this result. Similarly, Castle et al. (2008) did not find a significant effect for attitudes towards emotional expression. The reliability of this result was unclear, because it seemed like there were reporting errors in the study.

Hall and Long (2007) found that high role intensity ( $b = .15$ ), high role disparity ( $b = .16$ ), and poor life satisfaction ( $b = -.14$ ) accounted for 38% of postpartum depression (adjusted  $R^2$ ), independent of gender, while work-family strain was not significant. This study did not report results for men and women separately, but there was no significant difference between mothers and fathers. This study received high quality ratings throughout. Gender role stress was not a significant predictor in Morse et al. (2000). Soliday et al. (1999) found no evidence that coping style had an effect on depressive symptoms at four to six weeks postpartum, but prepartum parental stress predicted 14.1% variance of postpartum depressive symptoms ( $F = 9.66$ ,  $\beta = .44$ ,  $p < .01$ ).

## 1.4 Discussion

This systematic review examined the evidence from longitudinal, predictive analyses for psychosocial risk factors of postpartum depression in fathers. The findings of this review highlighted a number of risk factors which predicted subsequent PDS/PPD in fathers including: disconfirmed expectations of parenting demands, low parenting efficacy, low relationship satisfaction, being concerned/anxious about the birth, disagreement about pregnancy intendedness, low prenatal life satisfaction and stress, and high role strain. While most evidence was available for social support related risk factors, most high quality evidence suggested that low social support was not a significant predictor of PPD/PDS in fathers, however, there was some conflicting evidence. Parenting-related risk factors, on the other hand, had a small amount of high quality evidence that indicated that parenting stress and disconfirmed expectations of caretaking and parenting efficacy were predictive of the development of PPD/PDS. Two studies provided support of actual and expected negative experiences during child birth as having predictive value for postpartum depressive symptoms in fathers. The effect of father-infant bonding for the development of PPD was under-researched, but one study suggested that impaired bonding could be a risk factor, however, there was no longitudinal evidence for this. Research into marital/partner/family risk factors suggested that problems in the relationship and family, including disagreements about the pregnancy, increased the likelihood of fathers becoming depressed postnatally. Finally, individual risk factors were examined, but the predictive capacity of these is still unclear due to low quality research and lack of evidence. Only one high quality study indicated that high role intensity and disparity and low prenatal life satisfaction may be predictive of PPD/PDS in fathers. In summary, the evidence base for most potential risk factors is still sparse and will need further investigation. Relationship and parenting related risk factors were the most promising candidates for clinical intervention at this time.

The longitudinal evidence for disconfirmed parenting expectations, low parenting efficacy and relationship difficulties could be tied in with the theory that contemporary fathers may be dealing with changing expectations towards their father role (Singley and Edwards, 2015). While the concept of hegemonic masculinity has been consistently challenged in the past few decades (Connell, 2005; Donaldson, 1993), the public understanding of family and the parenting role is still often biased towards mothers and exclusive of fathers (Clapton, 2013). This is despite the evidenced familial and societal benefits of active fatherhood (Burgess, 2008). This balancing act of modern fathers may well lead to stress in fathers' parenting role, which could predispose fathers to PPD. However, in this review, gender role

stress had no direct predictive value for PPD/PDS in Morse et al. (2000), but it may still be linked to PPD indirectly through unmet expectations of parenthood, associated negative changes in the marital relationship and impaired father-infant attachment and this merits examination in future research. In a qualitative study, fathers' unfulfilled expectations of the father role (gender role stress) were found to have a negative impact on both fathers' satisfaction with their own parenting efficacy as well as the perceived marital satisfaction of both partners (Silverstein et al., 2002). Singley and Edwards (2015) suggested, based on the assumptions of Social Cognitive Theory (Bandura, 1986), that some fathers may feel unprepared and unskilled for the perceived demands of care-taking and nurturing an infant and therefore withdraw from this task. This could lead to a perceived failure in meeting society's and their own expectations of modern fatherhood, as well as impair father-infant attachment (Singley and Edwards, 2015).

The conflicting evidence about the relationship between lack of social support and subsequent paternal PPD suggested that this may not be as relevant a risk factor as has previously been assumed (Edward et al., 2015; Wee et al., 2011). Fathers may be less likely to seek outside support and more likely to rely on their partner for emotional support, highlighting again the role of harmony and mutual support in the marital relationship (Fischer and Good, 1997; Deater-Deckard et al., 1998; Huang and Warner, 2005; Escriba-Aguir and Artazcoz, 2011; Gawlik et al., 2014; Ngai and Ngu, 2015). When the couple is confronted with a host of challenges and potential conflicts regarding self-care, couple-care, and logistics of their care-taking roles, mutual support within the relationship is essential (Singley and Edwards, 2015). The lack of longitudinal evidence for PPD risk factors associated with social support is at odds with findings from cross-sectional research designs (Roberts et al., 2006; Gao et al., 2009; Gameiro et al., 2011; Mickelson et al., 2016). It may be that social support is a variable better examined cross-sectionally, given that it might be highly variable over time depending on the real time support needs of fathers during the pre- and postnatal period.

### *Recommendations for Clinical Practice*

The findings of this review suggested a number of issues that may be worth incorporating into clinical practice. Antenatal interventions targeted at parenting efficacy, birth concerns and expectations for the postpartum period (relating to the parenting role as well as relationship changes) might be helpful to relieve anticipatory and experienced distress of fathers and reduce the likelihood of the development of PDS/PPD. The findings of this review therefore provide further evidence in line with recommendations by May and Fletcher (2013) for the content of antenatal classes targeted at fathers. May and Fletcher (2013) highlighted the importance of postnatal relationship dynamics, such as preparing

fathers for the relationship and role changes, how to keep their relationship healthy, and how to build a strong parenting partnership with the mother. In addition, they recommended to improve fathers' parenting abilities by showing them how to effectively support the mother and thereby increase their own parenting efficacy, and how to improve father-infant bonding by developing their ability to identify and interpret infant communication (May and Fletcher, 2013). Finally, May and Fletcher (2013) suggested making fathers aware of the increased risk of developing pre- and postpartum mental distress and when to seek support.

Some antenatal and early postnatal interventions for fathers have been trialled, such as a male-facilitated male discussion forum, in which expecting fathers were able to freely talk and ask about issues they found important, including expectations for the postnatal period (Friedewald et al., 2005). The group evaluation was unanimously positive, but no randomised clinical trial was conducted to test for improved outcomes. Another targeted intervention to aid postpartum psychosocial adjustment in fathers and mothers only found significant reductions of psychosocial stress for new mothers, not fathers (Matthey et al., 2004). The authors thought their intervention had maybe been too one-sided and should in the future aim to increase the mother's understanding for her partner as well (Matthey et al., 2004). Specific interventions to improve the couple relationship during the transition to parenthood have been shown to be successful in reducing marital stress (Cowan and Cowan, 1995; Schulz et al., 2006; Mitnick et al., 2009). Giving fathers a choice about getting involved and support in making themselves heard in the birth process reduced fathers' anxiety and helplessness during birth (Bäckström and Hertfelt Wahn, 2011). Addressing these issues during antenatal classes as well as increasing sensitivity of clinical staff for fathers during birth may therefore be helpful for the prevention of PPD/PDS. It is important to note that based on the findings of this review only preliminary recommendations for psychosocial risk factors can be made and further high quality longitudinal research is required, which includes other risk factors, too, for example maternal PPD (Edward et al., 2015; Wee et al., 2011).

### *Limitations*

Certain characteristics of the studies reviewed limited the applicability of their findings. None apart from five studies provided confidence intervals, possibly making the interpretation of the results imprecise, as the reliability had to be rated based on information like number of participants and measures used. All psychosocial risk factors were assessed with self-report measures, introducing a reporting bias. The overall quality of evidence was acceptable with some exceptions in either direction. High quality evidence from studies with robust methodology and design is still limited and should be aimed for in future publications. Another limitation is the selectivity of the chosen samples. Most samples did not include

low-income families and fathers, and as per our inclusion criteria only samples with healthy infants and low-risk pregnancies were included. These findings therefore cannot be generalised to special populations (Clare and Yeh, 2012).

A meta-analysis to test the statistical strength of the findings across several studies was impossible for several reasons. Some risk factor categories did not contain enough studies, and there was a variety of constructs and measures used within each category. In addition, samples were recruited from a variety of backgrounds, and risk factors were assessed at a wide range of time points pre- and postnatally.

There were some methodological limitations of this review as well. As part of a doctoral dissertation, it was impractical to involve a research team with several independent raters in the whole process of study selection and quality rating. We attempted to compensate for this limitation by involving independent raters in a subset of studies at each step. Finally, our decision to include studies that screened for clinical case-ness as well as studies that examined a spectrum of depressive symptoms could have limited the clinical relevance of our findings. However, since 15 out of 18 included studies used either cut-off points or diagnostic interviews to determine case-ness, this was not a limitation.

### *Conclusions*

The risk of negative outcomes for new parents, their children and the partner relationship highlighted the need for further high quality longitudinal research of psychosocial risk factors for paternal PPD. The findings of this review suggested that targeting fathers' expectations of birth, their own role in parenting their children, the difficulties and challenges associated with parenting, as well as expectations of the impact of a child on the partner relationship may be beneficial in reducing paternal PPD. There is a need to increase health professionals' sensitivity for fathers and to address fathers' issues in antenatal care.

### *Acknowledgements*

The authors would like to thank Hannah Watkins and Joanna Chabinska who assisted with the selection and quality ratings of studies as independent raters.

### *Funding*

This research was undertaken in part fulfilment of a Doctorate in Clinical Psychology funded by NHS Education for Scotland.

*Declaration of Interest* – none.

## 1.5 References

- Areias, M., Kumar, R., Barros, H., Figueiredo, E., 1996. Correlates of postnatal depression in mothers and fathers. *The British Journal of Psychiatry* 169, 36-41.
- Atkinson, A.K., Rickel, A.U., 1984. Postpartum depression in primiparous parents. *Journal Of Abnormal Psychology* 93, 115-119.
- Bäckström, C., Hertfelt Wahn, E., 2011. Support during labour: first-time fathers' descriptions of requested and received support during the birth of their child. *Midwifery* 27, 67-73.
- Bandura, A., 1986. *Social foundations of thought and action: A social cognitive theory*. Prentice Hall, Englewood Cliffs, NJ.
- Bradley, R., Slade, P., Leviston, A., 2008. Low rates of PTSD in men attending childbirth: a preliminary study. *British Journal of Clinical Psychology* 47, 295-302.
- Bronte-Tinkew, J., Moore, K.A., Matthews, G., Carrano, J., 2007. Symptoms of major depression in a sample of fathers of infants: sociodemographic correlates and links to father involvement. *Journal of Family Issues* 28, 61-99.
- Burgess, A. (2008). *The Costs and Benefits of Active Fatherhood*. Online: <http://www.fatherhoodinstitute.org/uploads/publications/247.pdf>.
- Castle, H., Slade, P., Barranco-Wadlow, M., Rogers, M., 2008. Attitudes to emotional expression, social support and postnatal adjustment in new parents. *Journal of Reproductive and Infant Psychology* 26, 180-194.
- Clare, C.A., Yeh, J., 2012. Postpartum depression in special populations: A review. *Obstetrical and Gynecological Survey* 67, 313-323.
- Clapton, G. (2013). *Where's Dad? Father-Proofing Your Work*. Fathers Network Scotland. Online: [http://www.fathersnetwork.org.uk/wheres\\_dad](http://www.fathersnetwork.org.uk/wheres_dad).
- Connell, R. W. (2005). Hegemonic Masculinity: Rethinking the Concept. *Gender & Society*, 19, 829-859.
- Cowan, C.P., Cowan, P.A., 1995. Interventions to Ease the Transition to Parenthood: Why They Are Needed and What They Can Do. *Family Relations* 44, 412-423.
- Deater-Deckard, K., Pickering, K., Dunn, J.F., Golding, J., 1998. Family structure and depressive symptoms in men preceding and following the birth of a child. The Avon Longitudinal Study of Pregnancy and Childhood Study Team. *The American Journal Of Psychiatry* 155, 818-823.
- Dollahite, D.C., Hawkins, A.J., Brotherson, S.E., 1997. Fatherwork: A conceptual ethic of fathering as generative work, In: Hawkins, A.J., Dollahite, D.C. (Eds.), *Generative fathering: Beyond deficit perspectives*. Sage, Thousand Oaks, CA, pp. 17-35.
- Donaldson, M. (1993). What is hegemonic masculinity? *Theory and Society*, 22, 643-657.
- Edhborg, M., Matthiesen, A., Lundh, W., Widstrom, A., 2005. Some early indicators for depressive symptoms and bonding 2 months postpartum--A study of new mothers and fathers. *Archives of Women's Mental Health* 8, 221-231.
- Edoka, I.P., Petrou, S., Ramchandani, P.G., 2011. Healthcare costs of paternal depression in the postnatal period. *Journal of Affective Disorders* 133, 356-360.
- Edward, K.-I., Castle, D., Mills, C., Davis, L., Casey, J., 2015. An integrative review of paternal depression. *American Journal of Men's Health* 9, 26-34.
- Escriva-Aguir, V., Artazcoz, L., 2011. Gender differences in postpartum depression: A longitudinal cohort study. *Journal of Epidemiology and Community Health* 65, 320-326.



- Fischer, A.R., Good, G.E., 1997. Men and psychotherapy: An investigation of alexithymia, intimacy, and masculine gender roles. *Psychotherapy* 34, 160-170.
- Friedewald, M., Fletcher, R., Fairbairn, H., 2005. All-Male Discussion Forums for Expectant Fathers: Evaluation of a Model. *The Journal of Perinatal Education* 14, 8-18.
- Gameiro, S., Moura-Ramos, M., Canavarro, M.C., Soares, I., 2011. Network support and parenting in mothers and fathers who conceived spontaneously or through assisted reproduction. *Journal of Reproductive & Infant Psychology* 29, 170-182.
- Gao, L.-L., Chan, S.W.-C., Mao, Q., 2009. Depression, perceived stress, and social support among first-time Chinese mothers and fathers in the postpartum period. *Research in Nursing & Health* 32, 50-58.
- Gawlik, S., Müller, M., Hoffmann, L., Dienes, A., Wallwiener, M., Sohn, C., Schlehe, B., Reck, C., 2014. Prevalence of paternal perinatal depressiveness and its link to partnership satisfaction and birth concerns. *Archives of Women's Mental Health* 17, 49-56.
- Gotlib, I.H., Whiffen, V.E., Mount, J.H., Milne, K., Cordy, N.I., 1989. Prevalence rates and demographic characteristics associated with depression in pregnancy and the postpartum. *Journal of Consulting and Clinical Psychology* 57, 269-274.
- Gross, C.L., Marcussen, K., 2016. Postpartum Depression in Mothers and Fathers: The Role of Parenting Efficacy Expectations During the Transition to Parenthood. *Sex Roles*, 1-16.
- Hall, W.A., Long, B.C., 2007. Relations among prenatal role quality, life satisfaction, and dual-earner parents' postnatal depression. *Journal of Prenatal & Perinatal Psychology & Health* 21, 231-248.
- Hayes, A.F., Krippendorff, K., 2007. Answering the Call for a Standard Reliability Measure for Coding Data. *Communication Methods and Measures* 1, 77-89.
- Huang, C.-C., Warner, L., 2005. Relationship Characteristics and Depression among Fathers with Newborns. *Social Service Review* 79, 95-118.
- Johnson, M.P., Baker, S.R., 2004. Implications of coping repertoire as predictors of men's stress, anxiety and depression following pregnancy, childbirth and miscarriage: a longitudinal study. *Journal Of Psychosomatic Obstetrics And Gynaecology* 25, 87-98.
- Josefsson, A., Berg, G., Nordin, C., Sydsjö, G., 2001. Prevalence of depressive symptoms in late pregnancy and postpartum. *Acta Obstetrica et Gynecologica Scandinavica* 80, 251-255.
- Karukivi, M., Tolvanen, M., Karlsson, H., Karlsson, L., 2015. Alexithymia and postpartum anxiety and depression symptoms: A follow-up study in a pregnancy cohort. *Journal of Psychosomatic Obstetrics & Gynecology* 36, 142-147.
- Kerstis, B., Engström, G., Sundquist, K., Widarsson, M., Rosenblad, A., 2012. The association between perceived relationship discord at childbirth and parental postpartum depressive symptoms: a comparison of mothers and fathers in Sweden. *Uppsala Journal Of Medical Sciences* 117, 430-438.
- Leathers, S.J., Kelley, M.A., 2000. Unintended pregnancy and depressive symptoms among first-time mothers and fathers. *The American Journal Of Orthopsychiatry* 70, 523-531.
- Matthey, S., Barnett, B., Ungerer, J., Waters, B., 2000. Paternal and maternal depressed mood during the transition to parenthood. *Journal of Affective Disorders* 60, 75-85.

- Matthey, S., Kavanagh, D.J., Howie, P., Barnett, B., Charles, M., 2004. Prevention of postnatal distress or depression: an evaluation of an intervention at preparation for parenthood classes. *Journal of Affective Disorders* 79, 113-126.
- May, C., Fletcher, R., 2013. Preparing fathers for the transition to parenthood: Recommendations for the content of antenatal education. *Midwifery* 29, 474-478.
- Meline, T., 2006. Selecting Studies for Systematic Review: Inclusion and Exclusion Criteria. *Contemporary Issues in Communication Science and Disorders* 33, 21-27.
- Mickelson, K.D., Biehle, S.N., Chong, A., Gordon, A., 2016. Perceived Stigma of Postpartum Depression Symptoms in Low-Risk First-Time Parents: Gender Differences in a Dual-Pathway Model. *Sex Roles*, 1-13.
- Mitnick, D.M., Heyman, R.E., Smith Slep, A.M., 2009. Changes in relationship satisfaction across the transition to parenthood: A meta-analysis. *Journal of Family Psychology* 23, 848-852.
- Moher, D., Liberati, A., Tetzlaff, J., Altman, D., Group, T.P., 2009. Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. *PLOS Med* 6, e1000097.
- Morse, C.A., Buist, A., Durkin, S., 2000. First-time parenthood: influences on pre- and postnatal adjustment in fathers and mothers. *Journal Of Psychosomatic Obstetrics And Gynaecology* 21, 109-120.
- Ngai, F.-W., Ngu, S.-F., 2015. Predictors of maternal and paternal depressive symptoms at postpartum. *Journal of Psychosomatic Research* 78, 156-161.
- Paulson, J.F., Bazemore, S.D., 2010. Prenatal and postpartum depression in fathers and its association with maternal depression: A meta-analysis. *JAMA - Journal of the American Medical Association* 303, 1961-1969.
- Ramchandani, P.G., O'Connor, T.G., Evans, J., Heron, J., Murray, L., Stein, A., 2008. The effects of pre- and postnatal depression in fathers: A natural experiment comparing the effects of exposure to depression on offspring. *Journal of Child Psychology and Psychiatry* 49, 1069-1078.
- Roberts, S.L., Bushnell, J.A., Collings, S.C., Purdie, G.L., 2006. Psychological health of men with partners who have post-partum depression. *Australian & New Zealand Journal of Psychiatry* 40, 704-711.
- Rohde, P., Lewinsohn, P.M., Seeley, J.R., 1991. Comorbidity of unipolar depression: II. Comorbidity with other mental disorders in adolescents and adults. *Journal of Abnormal Psychology* 100, 214-222.
- Roubinov, D.S., Luecken, L.J., Crnic, K.A., Gonzales, N.A., 2014. Postnatal depression in Mexican American fathers: demographic, cultural, and familial predictors. *Journal of affective disorders* 152-154, 360-368.
- Schulz, M.S., Cowan, C.P., Cowan, P.A., 2006. Promoting healthy beginnings: A randomized controlled trial of a preventive intervention to preserve marital quality during the transition to parenthood. *Journal of Consulting and Clinical Psychology* 74, 20-31.
- Silverstein, L.B., Auerbach, C.F., Levant, R.F., 2002. Contemporary fathers reconstructing masculinity: Clinical implications of gender role strain. *Professional Psychology: Research and Practice* 33, 361-369.
- Singley, D.B., Edwards, L.M., 2015. Men's perinatal mental health in the transition to fatherhood. *Professional Psychology: Research and Practice* 46, 309-316.
- Soliday, E., McCluskey-Fawcett, K., O'Brien, M., 1999. Postpartum affect and depressive symptoms in mothers and fathers. *American Journal of Orthopsychiatry* 69, 30-38.

- Sussman, M.B., 1964. Use of the Longitudinal Design in Studies of Long-Term Illness: Some Advantages and Limitations. *The Gerontologist* 4, 25-29.
- Sweeney, S., & MacBeth, A. (2016). The effects of paternal depression on child and adolescent outcomes: A systematic review. *Journal of Affective Disorders*, 205, 44-59.
- Tuszyńska-Bogucka, W., Nawra, K., 2014. Paternal postnatal depression - A review. *Archives of Psychiatry and Psychotherapy* 16, 61-69.
- Wee, K.Y., Skouteris, H., Pier, C., Richardson, B., Milgrom, J., 2011. Correlates of ante- and postnatal depression in fathers: A systematic review. *Journal of Affective Disorders* 130, 358-377.

## 2. Bridging Chapter

Paternal depression has been studied in the wider context of its impact on parenting behaviours and outcomes for children. In a systematic review, Sweeney and MacBeth (2016) found that paternal depression was associated with internalising and externalising behaviours in offspring, at various stages of development from antenatal to postnatal stages, as well as adolescence. The strength of these negative associations was mediated by parenting behaviours, such as paternal hostility, father involvement, and father's negative expressiveness. Marital conflict was a further mediator between paternal depression and child internalising and externalising behaviours (Sweeney & MacBeth, 2016). The results of the systematic review in Chapter 1 found that low relationship satisfaction as well as parenting stress, disconfirmed expectations of caretaking and low parenting efficacy were risk factors for paternal postpartum depression. Combining our results with Sweeney and MacBeth's findings, marital difficulties could be a key factor in both the development of paternal depression as well as negative child outcomes. It could be hypothesised that parenting stress, disconfirmed expectations of caretaking and low parenting efficacy may not only lead to paternal depression, but also to later paternal hostility, less father involvement, and more negative expressiveness in fathers. These possible direct or indirect associations and their impact on child outcomes may merit further research.

A group of parents with high rates of depression are parents who are addicted to substances such as alcohol, cocaine or opiates (Swendsen & Merikangas, 2000). Substance use in parents with comorbid psychopathology comes with its own unique set of difficulties. Renk, et al. (2016) reviewed evidence for the neurobiological mechanism of the impaired ability to form emotional attachment in drug users and found that drug use affects the same neurotransmitter system as positive parent-child interactions – the dopamine-based reward and motivation system. Substance use therefore impacts the same system that is critical for parents' ability to invest in their children and form a secure attachment and consequently may interrupt these processes. Substance-using parents are therefore not only impaired by their mental health difficulties, such as depression, their substance use also adds an additional layer of parenting difficulty and risk for their children (Templeton, Zohhadi, Galvani, & Velleman, 2006).

Similarly to the research on postpartum depression, research on substance using parents is more numerous on the maternal side (Templeton, et al., 2006). This is despite the fact that compared to women, men have higher rates of comorbid depression and poly-substance abuse or dependence and higher rates of comorbid depression and other types of substance abuse or dependence (Fava, et al., 1996). Consistent with the self-medication hypothesis

(Khantzian, 2003), while opiates have depressant effects themselves, they are often reported in clinical practice to be used as anti-depressants based on their short-term psychological effects, such as euphoria, relaxation, or drowsiness (McKernan, et al., 2015). Depression was found to be a significant mediator between substance use and negative parenting behaviours in fathers (Stover, Urdahl, & Easton, 2012). Opiate use itself also comes with a host of longer term consequences, such as financial, health and social difficulties. Both short and long-term effects of opiates can have negative consequences on the parenting of children. How fathers experience these challenges will be dealt with in the next chapter.

## 2.1 References

- Fava, M., Abraham, M., Alpert, J., Nierenberg, A. A., Pava, J. A., & Rosenbaum, J. F. (1996). Gender differences in Axis I comorbidity among depressed outpatients. *J Affect Disord*, 38, 129-133.
- Khantzian, E. (2003). The self-medication hypothesis revisited: The dually diagnosed patient. *Primary Psychiatry*, 10, 47-54.
- McKernan, L. C., Nash, M. R., Gottdiener, W. H., Anderson, S. E., Lambert, W. E., & Carr, E. R. (2015). Further evidence of self-medication: personality factors influencing drug choice in substance use disorders. *Psychodyn Psychiatry*, 43, 243-275.
- Renk, K., Boris, N. W., Kolomeyer, E., Lowell, A., Puff, J., Cunningham, A., Khan, M., & McSwiggan, M. (2016). The state of evidence-based parenting interventions for parents who are substance-involved. *Pediatric Research*, 79, 177-183.
- Stover, C. S., Urdahl, A., & Easton, C. (2012). Depression as a mediator of the association between substance abuse and negative parenting of fathers. *Am J Drug Alcohol Abuse*, 38, 344-349.
- Sweeney, S., & MacBeth, A. (2016). The effects of paternal depression on child and adolescent outcomes: A systematic review. *J Affect Disord*, 205, 44-59.
- Swendsen, J. D., & Merikangas, K. R. (2000). The comorbidity of depression and substance use disorders. *Clin Psychol Rev*, 20, 173-189.
- Templeton, L., Zohhadi, S., Galvani, S., & Velleman, R. (2006). *"Looking Beyond Risk" Parental Substance Misuse: Scoping Study*. Edinburgh: Scottish Executive Substance Misuse Research Programme.

### **3. 'Hands on when able': How opiate using fathers make sense of their parenting experience**

Luisa S. Frei<sup>1,2</sup>, Roisin Ash<sup>2</sup>, Jill Cossar<sup>1</sup>

<sup>1</sup> University of Edinburgh, School of Health in Social Science

<sup>2</sup> NHS Lothian Health Board, Substance Misuse Directorate

Corresponding Author:

Luisa S. Frei

Trainee Clinical Psychologist

School of Health in Social Sciences

The University of Edinburgh

Teviot Place

EDINBURGH

EH8 9AG

Email: s1370095@sms.ed.ac.uk

Phone: 0131 650 3889

This journal article is written for submission at the International Journal of Drug Policy (Appendix B).

Abstract word count: 260

Main text word count, excluding tables, figures and references: 7782

## Abstract

**Background:** Parental substance use increases the risk for a variety of negative outcomes for children and this is linked to a negative stereotype of drug-using parents. Fathers' perspective on their parenting and the cross-generational transmission of associated risk for the child has not been examined. This study aimed to understand substance-using fathers' experience of parenthood, their insight into the process of transmission of risk, and any efforts to reduce this risk.

**Methods:** We used an interpretative-phenomenological approach to examine in depth the experience of a small sample (N = 6) of opiate-using fathers during semi-structured interviews.

**Results:** Fathers experienced a dichotomy in their parenting role, which was characterised as a 'disability' posed by their drug use. When 'disabled', fathers realised they could be selfish, neglectful and unable to meet their children's needs. When stable in their addiction or abstinence, the 'Able Father' was an involved, hands-on parent, sensitive to the child's needs and motivated to repair the ill-effects of being 'disabled' by addiction. By 'Connecting the Dots' with their own upbringing, fathers were motivated to be better fathers than their own fathers, but they only had partial insight into the risk their 'disabled' parenting posed for their own children.

**Conclusions:** The negative stereotype of the substance-using father warrants a more balanced appraisal. Their desire to be an 'Able Father' could be used as a motivating factor in drug and parenting interventions. Interventions aimed at increasing reflective functioning may contribute to positive outcomes for substance-using parents at the same time as reducing risk to their children, but more evidence is needed.

**Keywords:** father, drugs, opiates, reflective functioning, Interpretative Phenomenological Analysis, parenting

## Highlights

1. Fathers felt 'disabled' in their father role by their addiction.
2. They aspired to fulfil their own expectations of being an 'Able Father'.
3. The 'Able Father' was a motivating factor to become clean.
4. Participants wanted to be better fathers than their own fathers.
5. There was only partial insight into the transmission of risk for their children.

### 3.1 Introduction

In a scoping review of the literature on parental substance use it was found that a large part of the literature was concerned with the impact and risk associated with parental substance use (Templeton, Zohhadi, Galvani, & Velleman, 2006). Parental substance use in combination with domestic violence increased the likelihood of all forms of abuse and neglect for a child, and substance users were more likely to have experienced childhood maltreatment themselves (Templeton et al., 2006). Childhood maltreatment in turn propagated negative consequences for the child's development, including adolescent psychopathology, and a higher risk for adult relationship difficulties, negative parenting, perpetrating child abuse, substance use, or perpetrating/suffering domestic violence themselves (Templeton et al., 2006). It was proposed that the experience of neglectful parenting in childhood increased the likelihood of neglecting one's own children directly as well as indirectly by exposure to unsupportive and disorganised living circumstances (Dunn, et al., 2002), as can be the case in substance using environments (Kroll & Taylor, 2003, p. 118). Dunn et al. (2002) reasoned that childhood maltreatment can precipitate both adult substance use as well as childhood maltreatment of one's own children, a process of double cross-generational transmission of risk and vulnerability.

While the impact and risk of parental substance use were well researched, Templeton et al. (2006) also highlighted gaps in the literature, specifically the lack of research on paternal substance use as opposed to maternal substance use. In addition, they found that qualitative research on the views of parents, especially fathers, and children was scarce. Substance-using fathers were often only implicated by irresponsible reproduction and absence in their children's lives (Klee, 1998), mirrored in their absence within the research literature. This led to poor understanding and stereotyping of their psychological and behavioural profile (McMahon & Rounsaville, 2002).

Quantitative research within the past decade has begun to challenge the stereotype of the abusive, neglectful substance-using father. For example, McMahon, Winkel, Suchman, and Rounsaville (2007) found that even though only 28% of drug-using fathers still lived in the same household as their youngest child, 58% saw this child weekly or more often, and 82% provided financial support for this child. Similarly, although drug-using fathers had fathered more children with more women as non-drug-using fathers, they were just as likely to have planned the pregnancy of their youngest child, attended the birth, and formally acknowledged paternity (McMahon, Winkel, & Rounsaville, 2008). However, drug-using fathers reported less identification with the father role, a narrower range of (but not less) positive parenting behaviours and less involved interaction with their child and the child's



mother (McMahon et al., 2008). Crucially, drug-using fathers appraised their performance accordingly and were less satisfied with their parenting than non-drug-using men, indicating that although parenting can be compromised in fathers with problem substance use, they were aware of this and made efforts to be socially responsible fathers (McMahon et al., 2007, 2008).

Some qualitative studies examined the parenting experiences of substance-using mothers and fathers together. Barnard (2007) found that parents were very aware of their shortcomings, but unable to counteract the priority of their drug use over their parenting responsibilities resulting in the expected negative impact on their children. In contrast, Klee (1998) revealed that parents did make efforts to reduce the harm posed by their drug use, with varying levels of success, and that they felt a strong attachment to their children. For the parents interviewed by Rhodes, Bernays, and Houmoller (2010), damage limitation was a central theme, with an emphasis on good-enough parenting, damage acceptance, and child and self-protection through upholding of appearances. These findings suggest a more balanced view of substance-using parents, depending on varying levels of control over their substance use and parenting.

More recently, qualitative research has examined the experience of fatherhood separately. Peled, Gavriel-Fried, and Katz (2012) examined the development of fatherhood identity over the course of heroin addiction and recovery. They found that fathers often went from being absent to more involved after a moment of “awakening” from addict to clean addict. This awakening allowed them insight into their parenting behaviours and often evoked feelings of regret and guilt, as well as posing a motivation for recovery. Söderström and Skårderud (2013) identified three types of father identity in substance-using fathers: the Good Father, who was present, hard-working, reflective and caring, the Bad Father, who fell back into negative parenting practices from his past, and the Invisible Father, who felt ignored, left out and worthless. Two unpublished qualitative PhD dissertations highlighted the need to utilise fathers’ motivation and insight to make positive change. Taylor (2012) found that fathers thought that a problem drug-use career was incompatible with an active and involved fathering role. They had a desire to be better fathers, a desire the author suggested should be harnessed in drug treatment interventions. Whittaker (2008) described that fathers valued fatherhood and family life and believed in being involved and responsible fathers. They were aware of the cross-generational transmission of negative parenting and made practical efforts to change this (Whittaker, 2008). It is positive that fathers’ experiences have begun to be examined more closely in recent years. Findings highlighted two sides of the story. On the one hand, substance use was a significant impairment to fatherhood. On the other hand,

fathers had some insight into this and were striving to be better fathers, a motivational force that was often overlooked or dismissed, and rarely harnessed in drug treatment interventions.

The first aim of this study was to deepen the knowledge and understanding of drug-using fathers' experience of fatherhood. The second aim was to gain insight into fathers' recognition and interpretation of the mechanism of double cross-generational transmission of negative parenting practices and substance use and whether they undertook efforts to prevent this process from taking effect. Findings will be discussed in the context of extant literature and clinical implications.

## 3.2 Methods

### *Participants*

Eight male English-speaking participants took part in this study. All participants were current or past dependent opiate users (heroin, prescription pain-killing opiates or substitution therapy with methadone/buprenorphine), who had at least one biological or adoptive child under the age of ten, who they saw at least once per month. Men who were diagnosed with schizophrenia or acute psychotic episode were excluded from the study. Sixteen eligible men were identified and approached by their substance misuse service health professional during regular appointments, out of which eight men consented to take part in the study. Reasons for drop-out before consent were non-attendance or inability to be contacted (5), ineligibility (1) or change of mind due to stressful life circumstances (2). Two participants were excluded from data analysis after giving consent because none of their children were below ten years old. The six remaining participants were between 35 and 50 years old (mean 42) and had been using opiates for 3 – 23 years (mean 12.33). They had between one and four children, ranging in age from 1.5 to 21 years old. In addition to opiates, all of them had used a range of other drugs throughout their life time, such as benzodiazepines, cocaine, stimulant and other so-called 'party' drugs, cannabis or alcohol. All participants were currently engaged with health services. Five men received substitute or other prescribed opiates and one was abstinent at the time of interview.

### *Procedure*

Each participant attended one semi-structured interview lasting between 45 and 70 minutes. First, each participant provided informed consent. The aim was to ask all ten prepared questions (Table 3.1), but as per study protocol, probing questions were added if the interviewer thought it useful to follow up a particular topic to allow for a more thorough exploration of the participant's experience. Some questions were omitted if participants were uncomfortable to answer them in order to protect their emotional wellbeing. One participant

was reluctant to talk about details of his own childhood. Leading questions were avoided to give participants the chance to show whether they had insight into the mechanism of double cross-generational transmission of negative parenting and substance misuse without being explicitly prompted.

Interviews were recorded with an encrypted audio recorder and transcribed verbatim by the interviewer or a certified transcription service.

Table 3.1: Interview questions for the semi-structured interview.

<b>Influence of upbringing on parenting and substance use:</b>	
1.	(descriptive) Can you tell me about your children? <i>How many, how old, how much contact? Relationship to mother(s)? How do you share day-to-day parental responsibility?</i>
2.	(narrative) What was it like to become a father? <i>How did your life change after becoming a father for the first time/with every new child? What was life like before and after becoming a father for the first time/with every new child?</i>
3.	(evaluative) How would you describe yourself as a father? <i>What is important to you as a father? What kind of father do you want to be? How would other people describe you as a father? What are the challenges or difficulties for you as a father?</i>
4.	(narrative) How have you become the kind of father you are today? <i>What are the major influences that have shaped you as a father?</i>
5.	(descriptive) How do you combine your drug use with being a father? <i>What are the challenges for a father who uses drugs?</i>
6.	(narrative) Think about a father figure in your life when you were a child: What did you like about this person, what did you not like? <i>How has the relationship with this father figure shaped or influenced you?</i>
7.	(descriptive) Can you tell me about an important/memorable event in your childhood (this could be positive or negative)? <i>When you think about your own childhood, what is the first thing that comes to mind? Why is this important to you?</i>
8.	(comparative) If there was anything that you could change about your parenting, what would it be? <i>Why? Have you changed your approach to fatherhood in the past?</i>
<b>Fatherhood support*:</b>	
9.	(descriptive) What sources of support for your parenting, if any, do you currently have? <i>Partners, family, service?</i>
10.	(evaluative) Do you think there is anything the substance misuse service (SMS) could do to support you in your father role/parenting? <i>How could the SMS integrate your father role into your treatment in a useful way?</i>

\* Fatherhood support was a separate area of investigation in the original study proposal and will be dealt with in a separate publication.

### Data Analysis

Data were analysed with the help of nVivo 10 qualitative data analysis software (see Appendix D for a coding excerpt). An Interpretative Phenomenological Analysis (IPA) approach was chosen to develop insight into participants' lived experiences and

interpretation of these (Smith, Flowers, & Larkin, 2009). The IPA followed a classic staged iterative process of coding the transcripts for content and emerging themes, first individually for each participant and then participants as a group (Smith and Osborn, 2008). Finally, results were translated into a narrative, elaborating on and interpreting each theme in particular.

Care was taken to follow the measures for enhancing validity outlined by Yardley (2008). Triangulation was attempted by keeping a reflective journal for each interview, documenting the interviewer's feelings and impressions, to develop awareness of subjective bias and add an additional data source for interpretation. In addition, the interviewer attended regular supervision sessions with two different supervisors to reflect on interviews. One supervisor also aided with triangulation of the coding of two interview transcripts. A paper trail was kept throughout analysis, and disconfirming cases were noted and included in the analysis to provide a balanced presentation of the findings.

### *Reflective Notes*

I was aware of the impact a female student researcher could have on interview dynamics. I always introduced myself as a Trainee Clinical Psychologist and I had the impression the Psychologist title helped maintain a professional interaction, dealing with possible parental or sexual feelings towards me. I think my psychology background helped me keep a neutral, open and inquisitive stance, avoiding closed or leading questions, while being empathic and non-judgemental, allowing participants to be open and honest.

I started this project with a slight bias towards the fathers' perspective, unconvinced of the negative stereotype of the careless, irresponsible addict. During interviews I noticed that I was quite impressed with the fathers' stories, empathising with their struggle with addiction as well as their struggle to be better parents. When starting the analysis I took this into account to remain neutral and I had to admit that the negative stereotype did have a real basis in some situations. However, it can also not be denied that there was more to these men than the negative stereotype and I therefore saw my role in this analysis as introducing a balance.

### *Ethical Approval*

This study was approved by Scotland A Research Ethics Committee (15/SS/0039), NHS Lothian Research and Development (2015/0284), the NHS Lothian Substance Misuse Directorate Research Group and the University of Edinburgh Clinical Psychology Research Ethics Committee (Appendix C).

### 3.3 Findings

By far the most striking feature of the parenting experience of opiate-using fathers was dichotomy. Fathers felt that their drug use interfered with their parenting to a degree that there were two versions of them: the Able Father and the Disabled Father.

**Chris<sup>1</sup>:** How would I explain myself as a dad? No, I'm very hands on when able.

In order to identify the features of these two versions, fathers were guided by their own experience of being parented as well as by mistakes they had made themselves. This led to the emergence of three major themes: the Disabled Father, the Able Father and Connecting the Dots. Figure 3.1 provides an overview of the major themes and their sub-themes.

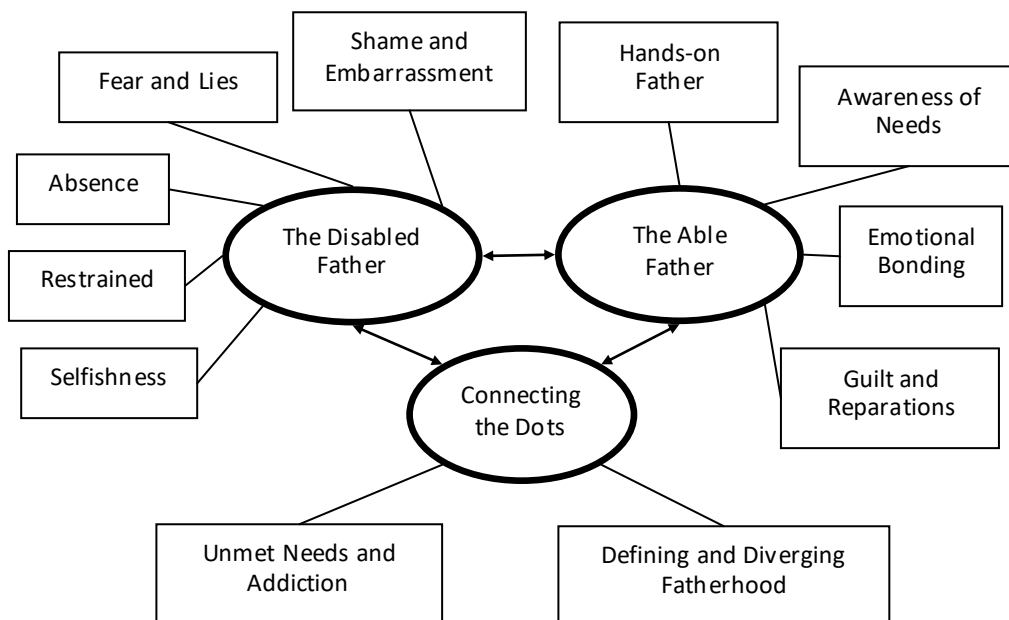


Figure 3.1: Graphical representation of major themes and their sub-themes.

#### *The Disabled Father*

The Disabled Father is a man who is struggling with or even fully controlled by his opiate addiction. He is caught in a circle of intoxication and withdrawal and neither of these states is conducive to the parenting task. With the focus on drug-related tasks, such as obtaining drugs, using them or securing the financial means necessary, there is not much space in the mind of the drug-addicted father for anything but himself and his addiction. This can turn

<sup>1</sup> All names were changed to protect participants' identities.

him into a selfish, careless and ignorant parent, who will have no insight into anyone's needs but his own (sub-theme '**Selfishness**').

**Iain:** ... I mean, when you're in addiction, you're the most selfish people going, I certainly was. I didnae worry about what affected anybody else, it was all about me. And all about me getting my fix. Em, feeling like the world was owing me a favour, ken, feeling hard done by all the time.

Iain recognised that he was selfish when he was in active addiction, but he also added that he did not care about how his actions affected others and that he did not understand other people's thoughts and motivations, leading him to feel resentment towards others, which he later felt was unjustified. It can easily be seen how this state of mind could obscure the task of parenting a child. When disabled, a common reaction of the interviewed men was to withdraw from their parenting responsibility altogether (sub-theme '**Absence**').

**Interviewer (I):** Yeah, why was it that you stopped seeing her?

**John:** Eh, I was getting too involved with the drugs and I didnae want to turn up ... I've never wanted to be... How can I explain it? Em, I've never really wanted to be out of my face on drugs when I've been near my kids. I would usually go and hide away and take my drugs. Know what I mean?

[...]

**I:** Yeah, ok, so you seem to have the feeling that, ok, it's getting extreme now with the drugs, so I'm gonna stay away from my kids, so... Why is that, do you have an idea?

**John:** I don't know, I just...I don't... Well, I've seen people on drugs with their kids and that's not how I want to be with my kids. I wannae be responsive and be there for them, not just sitting there and ... ah, slaving away or you know, be incoherent to them. With kids you've got to be full on. You know what I mean?

John had an acute awareness of his reduced ability to respond appropriately to his children's need for consistency and connection. For John, it seemed more important to meet these needs completely ("With kids you've got to be full-on") than failing his own parenting standards. As a consequence he stayed away from his children for months or years at a time and this resulted in inconsistency and abandonment of his children, the very things he had aimed to avoid. Actual physical abandonment was not an option for everyone though.

**Billy:** Well the kids have always stayed with me. I mean, I had two kids with her, but I've always had my own place to stay. And every time we fell out, I'd take M1<sup>2</sup> and M2 with me. And then eventually I got custody of them. And apart from until recently they've all been with me all their life. Even M3, I wasn't really with their mother at the time, I just saw her on certain weekends, just now and again, then M3 came along. [...] He's never been away from me, hardly, from the day he was born.

---

<sup>2</sup> Children's names were anonymised with a code representing gender (M, F) and birth order (1, 2, 3, etc.).

It is interesting to note that Billy put a lot of emphasis on the timescale, using expressions like “always”, “all their life” and “from the day he was born”. This suggested that he had an implicit awareness of the need for consistency and connection. Billy described managing to organise his alcohol use around his parenting responsibilities throughout his children’s lives, but after starting to use heroin he eventually realised that he was not able to meet his children’s needs anymore and sought help for his addictions.

**Billy:** Nah, see, like I said for whatever reason I was still able to make teas and what not. Maybe I wasnae giving very good ... it just didn’t seem to be affecting my ... at first, like I said. Now thinking back, it must have, but at the time it didn’t seem like it did, cause my kids meant that much to me as well. I was sort of torn between them both.

**I:** between...?

**Billy:** Well, eventually, the heroin was taking over and that’s when I came here. Cause it was either that or my kids were out for the night.

Billy mentioned meeting his children’s physiological needs like food, but did not articulate what else he may have been (un)able to provide. Putting his children out for the night would have meant not providing them with a safe home and it was then that he decided to put his children’s needs before his own need for heroin. Billy thought that he was able to provide for his children’s basic needs up until this point in his addiction, but also conceded that maybe he was unaware of not being able to meet other needs, possibly emotional needs. Chris was able put this words:

**I:** So not, not, you know kind of being absent from their lives almost [yeah, yeah] although you were physically there.

**Chris:** Aye, aye, that’s it, I was there but I wasn’t really into that doing, doing, I’ve got high standards tae, ken so aye, I wasn’t being the standard of dad that actually I felt like I should’ve been.

[...]

**Chris:** I mean I’ve bonded with F1 as well, but F2, it’s ‘cause of that bonding that I’ve done I can see the special wee things, eh [yeah, yeah] and sometimes aye if you’re on drugs and that you can overlook they, you can overlook their wee special things. [...] I ken [ed.” you know”] I missed oot on all their special wee things and that and it wisnae until, it wisnae until I started getting control of that and then I started get that spending some time with them ken, noticing wee things that I, ken, you just notice wee things about their characters, ken wee things that make you love your kid that you ken that makes you think that they’re special all that wee bit more.

Chris recognised that his drug-induced inability to have an emotional connection with his children was against his ideals of fatherhood, which was to be emotionally available for his children and keep the strong bond he had with them. When in active addiction, he was unable to fully appreciate why he loved them and why he wanted to be there for them. For

the fathers in this sample, '**Absence**' therefore encompassed not only physical abandonment, but also emotional absence and lack of bonding.

Another sub-theme of the Disabled Father theme was the experience of being '**Restrained**' in their father role. This was usually caused by circumstances related to the addiction, for example financial difficulties, rehabilitation, or restrictions imposed by partners or social work. Iain decided to go into a rehabilitation programme at a time when his son was put into kinship care:

**Iain:** Although I wasn't in a position, when he was taken from his mum, I wasn't in a position to be able to take him. 'Cause I was treating my drug addiction. And I was just getting ready to come into [rehab programme]. So, I didn't have a house either, I was staying with my dad at the time. So I mean it wasnae possible for me to take him. Because there was a break down between mine's and his mum's relationship, his mum didn't get on with my family, she wouldn't allow my family to see him or have anything to do with him. So it was her choice to put him where he is now. Em, she got asked whether there was anybody who could take him and she chose the person who he is with. That certainly wouldn't have been my choice. I believe he should be with his family.[...] Em, just now it's quite hard because I'm not getting much time with him. It's more than what I was getting before he got taken from my ex, but it wasnae until he was taken from her that I started getting contact again. Because it was taken out of her hands, and now put in social work hands, so that's why I'm in for contact again. And it's quite difficult because I don't get long with him.

Iain's feeling of being restrained in his ability to be a father for his son was caused by several external factors, such as his partner's refusal to grant him contact, his recovery from addiction, as well as social work restrictions of supervised contact. He recognised that the latter was a current obstacle to build a relationship and repair the bond with his son.

Intuitive awareness of fathers' own parenting shortcomings often resulted in a fear of losing their children to social work (sub-theme '**Fear and Lies**')

**Jack:** I hid it well, yeah cause I was just no' wanting to fail with my children, so and that's one thing, that people that take opiates that have children are good liars  
**I:** Okay and they will try and deceive  
**Jack:** Yeah, yeah, I done it, I done it myself but now, no' now, a while back I realised, know, that help is there as it says, help and I thought if I ask for help they might think I'm toiling and you know so yeah, yeah there was a bit of fear there as well.

Jack feared that if his parenting difficulties came to light, social work were likely to take his children into care. For him that would have meant a personal failure and admitting that he had failed his own children would likely have cost him his own self-esteem. This fear was so strong that it prevented him from asking for help and instead he tried to hide his shortcomings, to the likely detriment of his children. This example highlights another



consequence of the 'Disabled Father': '**Shame and Embarrassment**' over their inability to meet their children's needs, and a hurt pride for failing in their father role.

Addiction to opiates had a disabling effect on all participants, be it a direct result of intoxication and withdrawal leading to psychological and/or physical absence from their children's lives or be it the more long-term consequences of addiction, such as financial problems or children being in care, which resulted in the inability to provide for their children's needs. Many of them took steps to reduce the impact of their drug use on their children. Fathers' insight into this 'disability' varied depending on whether they were in active addiction, or whether they were stable on either an opiate prescription or in abstinence. Even intuitive awareness provided a basic level of understanding of their shortcomings. The consequence of this awareness was shame and embarrassment over their perceived failure as dads, feelings that resulted in fear of losing their children and inhibitions to ask for help from services.

### *The Able Father*

The flip side of the Disabled Father comes to light when fathers are either drug-free, in relatively controlled stages of addiction or stable on substitute prescriptions. The Able Father takes pride in being responsible, protective, hands-on, connected and a provider. In this role, fathers become more receptive to their child's needs and state of mind. The Able Father is who they want to be.

**Steve:** ...sitting and watch a video or we'll sit and we'll make things or we'll paint or we'll draw or destroy things as well [chuckles], like playing and tumbling things down the stairs or... We made like a, a wee, inside the house, my mum goes to Costco and buys like packets of toilet roll, packets! So we made a toilet roll house yesterday, just inside the house, for a wee while and then we went out picking berries, and different sort of petals and stuff, to let them see what smells and stuff there was, and ...[...] I done a lot as a dad. I would get up and do night feeds, I was taking them into nursery, I was picking them up from nursery, I would make the bottles at night before they were getting done, I would change nappies... Because my partner worked, I made sure that I was doing as much as I could, tea was ready for her coming in, and they would be bathed every night, and the kids were always looked after, eh?

Steve's example highlighted the emphasis on being a '**Hands-on Father**' (Appendix D), expressed in the involvement and responsibility he put in his parenting role, and the resulting joy and gratification he experienced himself. All fathers had an ideal image of being a hands-on, responsible and involved father and most managed to achieve this ideal unless their addiction had become too strong. It was important for them to be present and approachable and look after their children's needs. Chris related how he responded flexibly to the different needs of his younger and older daughters (sub-theme '**Awareness of Needs**').

**Chris:** My eldest, I mean I'm there just if she wants something, Dad can you drop me here or can you come to the bus stop at half 10 to meet me 'cause it's dark and [Uhuh] ken that's my role with my eldest one, but with my youngest one aye, I, I'm her play toy. I need to be there to, she's got so much energy and stuff I need to be there to keep her, even, even if she's watching the TV, my daughter she'll be watching TV on the stool and then she'll get up and the stool will be upsides down and then she'll get, she just can't sit still so aye, I'm, when I'm able I'm very, very hands on and aye, always, always where I'm coming up with things that, to try and I'm not, I'm not a dad who, I don't, not that I don't think that she's safe but I think that F2's not got the, the mentality yet to be out with like friends her age.

Chris appeared particularly attuned to his younger daughter with special needs with an awareness of her vulnerability that allowed him to try to manage risk associated with her behaviour. This image of the Able Father was a source of great pride for all participants in this study. Not only did they have a heightened awareness of their children's needs, they also had a heightened awareness of the ill-effects the Disabled Father had had on their children. Coming to terms with having failed their own parenting standards, dealing with the associated guilt and making reparations (sub-theme '**Guilt and Reparations**') for their previous shortcomings was another essential aspect of the Able Father.

**Chris:** I feel guilty, ken, I really do, aye, I feel guilty aye and I mean eh ken I'm saying about F2 as well and she brings me oot of it, that, that's at the moment ken when I'm in a bad mood, ken, ken, I'll be ... ken, that they're in my bag or whatever and ken I'm feeling terrible and she comes, that's the thing, that wouldn't have happened like the first time before my relapse the first time aye, nothing would have pulled me oot of that ken, aye. So now, now aye, that's my worst thing I would say is, is guilt. Ken I feel guilty for taking it and that's the thing with my parenting that I'd like to change eh, hence why I came to the services and stuff aye.

Chris was stable on an opiate prescription, but still being addicted and having to rely on his prescription while looking after his daughter, as well as his previous psychological absence when 'disabled' was associated with feelings of guilt. He was able to see the improvement in his recovery because he was now approachable for his daughter even when feeling quite low and in withdrawals. Nevertheless, he realised this was not enough and took this as a motivation to seek help from addiction services. Fighting the addiction was not the only change fathers made as a result of the discrepancy between the 'Disabled Father' and the 'Able Father'. Some took active steps to repair the damaged emotional bond (sub-theme '**Emotional Bonding**') with their children.

**Iain:** The time with him is mostly spent just really trying to have fun with him, trying to build that bond up again with him. Trying to be his friend. As much as I'd like to try and be a dad more, I feel like... I was just coming back into his life when he didnae need somebody else, kind of telling him what to do. Felt like I had to build a friendship up with him first, and then set boundaries with him. Just try and be a dad, I mean, all I can go on really is the dads that I knew, ken, my own dad. [...]

Aye. It's almost like it's too little too late. But... I want him to know at least that his dad's there now. Whether he gets to come home with us or not, his dad will always be there. And hopefully his dad is going to be somebody he can rely upon, should he need him. [...]

But I feel like I always need to reinforce it to M1, probably because I do feel like I've let him down so much and maybe he doesn't know that I love him. And his dad's not been there, so how would he? Em, so maybe I feel like I need to... reinforce that by telling him.

Iain tried to make reparations to fulfil his son's need for consistency, reliability, love and connection. However, he highlighted that making reparations was not a straightforward process. He was riddled with self-doubts about whether his son would accept him back and he realised that he had to repair the emotional bond first, something he called 'building a friendship'. He realised that being a father who is also respected for his authority (something he perceived as being essential to fatherhood) required a foundation of consistent love, trust and connection.

In summary, the Able Father was a goal that required committed action and this was only possible when a father was stable on a prescription or abstinence. Being able meant being involved, hands-on, responsible and attuned to their children's needs. It also comprised dealing with the guilt and ill-effects of the Disabled Father, making reparations and slowly building up the damaged bond to achieve the Able Father image, which appeared to be a motivating force to become abstinent. In this last quote, Iain mentioned that he tried to be a father for his son based on the example of his own father. This will be explored in the final theme.

### *Connecting the Dots*

While the previous theme tapped into how the fathers grew into their role over time by recognising and correcting mistakes they had made during active addiction, this theme is concerned with how they developed their ideal of the Able Father and how they drew connections between their own upbringing, their parenting experience and their addiction.

In the sub-theme '**Defining and Diverging Fatherhood**', fathers drew on experiences of their own fathers to define the father they wanted to be. This was often marked by a divergence from their own father's parenting. All participants experienced disconnection and abandonment from their fathers to some extent. While for some this was marked by neglect, physical or emotional abuse, loss through suicide or physical absence, for others it was an emotional distance, a lack of bonding within the father-child relationship. This experience of disconnection was one they attempted to counteract with their own children, and this contributed significantly to what they thought was essential for the Able Father, as illustrated by John:

**John:** Em, I never got to see my dad when I was younger and I always wanted to see my dad. And I thought “If I have kids, I’ll never ever put them in that predicament, no matter what, I’ll always try and be there for them.”

For John, being able meant being physically as well as psychologically present. John also experienced extreme poverty, neglect and physical abuse and this led him to incorporate the provider as well as the protector role into his image of the Able Father.

**John:** Well, I don’t ever lift my hands to my kids and I even says to my ex and her boyfriend “Listen, if you ever lift your hands to my boys, I’ll be round to see you”. I said “I never lifted my hands so you won’t” – “Aw, I’m no like that”. So I said “That’s just as well.”

In contrast, Steve remembered growing up in a safe home with all physical needs being met. However, he found it difficult to establish a close bond with either parent and described his father as authoritarian, emotionally abusive and not interested in spending quality time with his sons.

**Steve:** Eh, it’s like I never really wanted for much in my life, but the things that I did want, I had like, I couldnae get a proper relationship with my parents. ‘Cause my mum brought us up, she never really had time for questions and talking about how you felt, and my dad was sorta like the enforcer for coming in at night and keeping the discipline. So it was like, I grew up pretty sorta shut down, if that makes sense. [...] And he worked all the time, so, it was like, I used to ask my dad to take us to football matches and stuff, and he would never ... take us or, ken, it was different, like everybody, or a lot of people were having, their dads loved football and, do you know what I mean?

For Steve, therefore, spending individual quality time with his children was crucial in his view of the Able Father and this became apparent when he related his difficulties with only being allowed to see his children for three hours a week:

**Steve:** Like I would, what I would like to do is like allocate some of my time to my son, and some of my time to my daughter, and then time with the both of them, together. Because two different kids, and different ages and one’s a wee boy and one’s a girl, they’ve got different things. And it’s hard trying to find that, it’s hard trying to say, ok I’ve only got three hours, what am I gonna do that both of them like?

The drug-using fathers’ experiences of being brought up were therefore essential in how they wanted to parent their children, in an effort to save their children from the same experience. Some fathers were also able to reflect on what caused themselves to become addicts (sub-theme ‘**Unmet needs and addiction**’). Steve made the poor relationship, over-bearing authority and his parents’ high expectations of him responsible for his vulnerability to addiction.

**I:** ...Em, how do you think the relationship with your parents has influenced you?

**Steve:** It's no' been great, eh? It's like, I would say, it's made my addiction a bit worse, cause like, they've like got such high, like... they expect me to do so well, and this and that, em, but the fact, if they would listen to me a bit more, em, and see, I dinnae think they ken, they cannae allow me to be a dad, cannae, it's like they cannae allow it, it's like they cannae help themselves but try and control me still. And I feel there's no' any difference between the way they speak to me, talk to me and deal with me now, as there was when I was 16. Em, which is hard work.

Despite his age, Steve felt the relationship with his parents had not changed since childhood and he suffered from the effects of it, making him feel inferior to them (like a 16-year old). He made the psychological connection between his feeling of not being good enough for his parents' expectations and his need for drugs as a coping mechanism, to help him deal with the ongoing battle against his low self-esteem and low self-efficacy ("hard work"). Psychological mechanisms relevant to the etiology of addiction were highly individual for each participant. In contrast to their conscious efforts to be better fathers than their own fathers, only some explicitly stated the cause or function of their drug use as being their own experience of poor parenting. This could in part explain why none of them explicitly spoke about any efforts to be better parents in order to direct their children away from a future with drug addiction. However, there was awareness of risk for their own children becoming involved with drugs.

**Billy:** And you try to explain to him that drugs are no good for you and eh, whatever have you. You hope your kids are no' gonnae go down the same road. 'Cause it's all gonnae be there for them.

Billy tried to prevent his son from using drugs by telling him about their bad effects. However, he seemed to feel quite helpless, thinking this was the only way to protect his son from using drugs. Billy appeared to have little awareness of how meeting a child's needs could have a protective effect. Others seemed more aware of the overall benefit of meeting children's needs, but there was no explicit indication that these men were aware that this could have a role in preventing their children from using drugs in the future. Regarding the double cross-generational transmission of negative parenting and substance use, it seemed that the men in this study had a one-sided awareness of the transmission of negative parenting practices, and were not necessarily aware of how negative parenting may impact on the transmission of substance use for their own children.

### 3.4 Discussion

This study aimed to understand opiate-using fathers' experience of fatherhood and their insight into the cross-generational transmission of negative parenting experiences and substance use. The fathers in this study understood themselves in two distinct roles, as an 'Able Father' and a 'Disabled Father'. While the 'Able Father' was an aspired role, characterised by hands-on involvement, emotional bonding, providing for a child's needs and repairing the damaged father-child relationship, the 'Disabled Father' failed in these aspects and was unable to understand and provide for the needs of the child. This dichotomy fits in well with findings from the existing qualitative literature on drug-using fathers that highlighted the 'Good Father' and the 'Bad Father' (Söderström & Skårderud, 2013) and the 'awakening' from absent to present father (Peled et al., 2012). There were also parallels with the findings on substance-using mothers, who had high standards of mothering, but were aware of addiction-related parenting shortcomings (Hardesty & Black, 1999; Kearney, Murphy, & Rosenbaum, 1994; Klee, 1998; Richter & Bammer, 2000). As in other studies, a perceived discrepancy between the 'Able' and 'Disabled Father' was often a motivation to seek help from services (Taylor, 2012; Whittaker, 2008). Fathers explained this dichotomous experience on the background of their substance use and their own experiences of being parented. In the theme 'Connecting the Dots', fathers drew clear connections between not having had their own needs met as children and efforts to give their children a different parenting experience. Fathers described some basic awareness of their own deficient upbringing making them more vulnerable to drug use. However, it was striking that there was a lack of expressed awareness about how their own parenting could influence their children's risk for drug use.

'Disability' consisted of a lack of awareness and interest in the needs of others and a lack of empathy for others' state of mind. Children have both physical and emotional needs (Tay & Diener, 2011), and if these are not met, it can have detrimental outcomes for the affected child (Kroll, 2004; Solis, Shadur, Burns, & Hussong, 2012). This lack of insight in drug-using fathers has also been highlighted by Söderström and Skårderud (2013). Reflective Functioning (RF) encompasses both the ability to be aware of one's own state of mind as well as of another person's state of mind (Allen and Fonagy, 2006). Fonagy, Steele, Steele, Moran, and Higgitt (1991) postulated that parental RF is essential for the secure attachment of children, by way of understanding and responding to a child's needs consistently. An impairment in RF may not only impact on attachment processes, it may also play a role in fathers' insight into the double cross-generational transmission of negative parenting and substance use. In order to understand this process, a drug-using father needs to understand how his own experiences of being parented have influenced his current state, and also how

his children may be impacted by the same or similar experiences as a result of his own parenting behaviours.

In a quantitative review, Katznelson (2014) concluded that substance-using mothers' self-related RF in particular was central to the ability to parent their children. However, there is a dearth of research on RF in substance-using fathers and the only two studies found no effect of RF on fathers' observed and self-reported parenting behaviours (Stover & Kiselica, 2014; Stover & Coates, 2016). In a qualitative study, substance-using fathers who perpetrated domestic violence were also found to have difficulties with emotional awareness of anger and guilt (Stover & Spink, 2012). The lack of evidence regarding RF in substance-using fathers and the risk for negative outcomes for their children highlight the urgent need for further research in this area.

The results of this study suggest that fathers often realised that their substance-induced lack of insight into their children's and their own mental state could be problem for their parenting. These results therefore add further support to the proposed interconnectedness of RF, attachment, parenting ability and substance use. Therefore, attachment-based parenting interventions that address RF in substance-using parents could be considered in the treatment of fathers with addiction (Renk, et al., 2016). There is emerging evidence for the effectiveness of attachment-based interventions with substance-using mothers to increase RF and secure attachment with their young children (Renk et al., 2016). However, fathers have been neglected in this area of research so far. A recent programme that has been proposed for substance-using fathers is based on a scaffolding approach to increase safety and improve RF (Torres, Sng, & Deane, 2015). Torres et al.'s (2016) approach is aiming "to increase awareness of complex trauma and attachment issues and improve the quality of parent-child relationships as well as parenting self-efficacy, which we hypothesise will lead to caregivers feeling more confident in continuing to seek further support with parenting". There is no evidence yet as to the effectiveness of such an approach, but the findings of this study provide some support for its premises. If RF was indeed central to fathers' parenting abilities and father-child attachment, this would also highlight the need to increase staff awareness of this psychological process and the need for skilled intervention.

It is striking that the length of sample quotes used in this study is rather long. On the one hand, this could be a preference of the researcher. However, it may also be a reflection of fathers' difficulty with RF and translating complex mental states into words. Alternatively, intoxication with opiates themselves may have had an effect on participants' verbalising.

Clinical implications of this study concern the difficulty of engaging fathers in drug and/or parenting interventions (Fiorentine, Nakashima, & Anglin, 1999). A common theme between

this and other studies (Peled et al., 2012; Söderström & Skårderud, 2013; Taylor, 2012; Whittaker, 2008) was fathers' motivation to become better fathers by overcoming their addiction. This motivation should be openly acknowledged and harnessed by health professionals to improve their clients' outcomes. In order to engage fathers in parenting interventions, health professionals should be aware that fathers may either be lacking insight into their own parenting difficulties or that they might be anxious to admit to them. An educational, empathic and supportive approach to disclosure of parenting difficulties may be more fruitful than a punitive approach, by way of empowering the father in his parenting ability and reducing the risk to his children (Dawe, et al., 2007; Finn & Jacobson, 2003).

### *Limitations*

The compromise in qualitative methods is for rich and contextualised data over sample size, which naturally limits generalisability. We chose a small, homogeneous sample of opiate-using fathers, following recommendations of Smith et al. (2009), to allow for greater depth of phenomenology and interpretation of the data. The researcher's own bias will have had some impact on the objectivity of the findings, limiting their generalisability further. Due to academic constraints it was not possible to analyse the data in a research team, but we made efforts to triangulate and discuss a subset of the data. For the same reason, it was impossible to gather participant feedback on the data analysis. There is the possibility of a self-selection bias within the sample, supported by a high drop-out rate of 50%, as it may exclude those fathers who are in more chaotic life circumstances, whose children are at higher risk or who have less insight into their father role. Health professionals who approached their clients may also have pre-selected those fathers who were better at verbalising and RF.

### *Conclusions*

The relative absence and neglect of the substance-using father in the research literature as a resource rather than a risk for their children is in the process of being overcome by evidence from this and other qualitative studies. A more balanced picture of the stereotypical irresponsible and selfish drug addict is emerging. While the stereotype may be true in stages of active, uncontrolled addiction, substance-using fathers also had personal ideals of fatherhood and these motivated them to be better fathers. Addiction services may be able to harness this motivation by helping men reflect on their father role, the effect of their own upbringing on their drug use and the effect of their parenting on their children. Alongside current intervention approaches, drug treatment interventions and parenting interventions that strengthen reflective functioning in substance-using fathers and mothers may improve outcomes for drug users and their children. Research on the role of RF in the parenting of substance-using fathers, as well as randomised controlled trials for interventions which aim to improve RF in all substance-using parents, could further elucidate how RF could be



utilised to improve drug treatment outcomes and reduce the risk for children by strengthening parents' parenting abilities.

*Funding Sources*

This research was undertaken in part fulfilment of a Doctorate in Clinical Psychology funded by NHS Education for Scotland and therefore minimum expenses incurred (i.e. stationary, printing, participant payment, voice recorder and transcription kit) were met by either NHS Lothian Health Board or the University of Edinburgh.

*Declaration of Interest* – none.

### 3.5 References

- Allen, J. G., & Fonagy, P. (2006). *The handbook of mentalization-based treatment*. Chichester, UK: John Wiley & Sons.
- Barnard, M. (2007). Parenting in the Midst of a Drug Problem. In *Drug addiction and families*. London, UK: Jessica Kingsley Publishers.
- Dawe, S., Frye, S., Best, D., Moss, D., Atkinson, J., Evans, C., Lynch, M., & Harnett, P. (2007). *Drug use in the family: impacts and implications for children*. Canberra: Australian National Council on Drugs.
- Dunn, M. G., Tarter, R. E., Mezzich, A. C., Vanyukov, M., Kirisci, L., & Kirillova, G. (2002). Origins and consequences of child neglect in substance abuse families. *Clinical Psychology Review*, 22, 1063-1090.
- Finn, J. L., & Jacobson, M. (2003). Just Practice. *Journal of Social Work Education*, 39, 57-78.
- Fiorentine, R., Nakashima, J., & Anglin, M. D. (1999). Client Engagement in Drug Treatment. *Journal of Substance Abuse Treatment*, 17, 199-206.
- Fonagy, P., Steele, M., Steele, H., Moran, G. S., & Higgitt, A. C. (1991). The capacity for understanding mental states: The reflective self in parent and child and its significance for security of attachment. *Infant Mental Health Journal*, 12, 201-218.
- Hardesty, M., & Black, T. (1999). Mothering Through Addiction: A Survival Strategy among Puerto Rican Addicts. *Qualitative Health Research*, 9, 602-619.
- Katznelson, H. (2014). Reflective functioning: A review. *Clinical Psychology Review*, 34, 107-117.
- Kearney, M. H., Murphy, S., & Rosenbaum, M. (1994). Mothering on crack cocaine: A grounded theory analysis. *Social Science & Medicine*, 38, 351-361.
- Klee, H. (1998). Drug-using parents: analysing the stereotypes. *International Journal of Drug Policy*, 9, 437-448.
- Kroll, B. (2004). Living with an elephant: Growing up with parental substance misuse. *Child & Family Social Work*, 9, 129-140.
- Kroll, B., & Taylor, A. (2003). *Parental Substance Misuse and Child Welfare*. London: Jessica Kingsley Publishers Ltd.
- McMahon, T. J., & Rounsaville, B. J. (2002). Substance abuse and fathering: adding poppa to the research agenda. *Addiction*, 97, 1109-1115.
- McMahon, T. J., Winkel, J. D., & Rounsaville, B. J. (2008). Drug abuse and responsible fathering: a comparative study of men enrolled in methadone maintenance treatment. *Addiction*, 103, 269-283.
- McMahon, T. J., Winkel, J. D., Suchman, N. E., & Rounsaville, B. J. (2007). Drug-abusing fathers: Patterns of pair bonding, reproduction, and paternal involvement. *Journal of Substance Abuse Treatment*, 33, 295-302.
- Peled, E., Gavriel-Fried, B., & Katz, N. (2012). "I've Fixed Things Up": Paternal Identity of Substance-Dependent Fathers. *Family Relations*, 61, 893-908.
- Renk, K., Boris, N. W., Kolomeyer, E., Lowell, A., Puff, J., Cunningham, A., Khan, M., & McSwiggan, M. (2016). The state of evidence-based parenting interventions for parents who are substance-involved. *Pediatric Research*, 79, 177-183.
- Rhodes, T., Bernays, S., & Houmoller, K. (2010). Parents who use drugs: Accounting for damage and its limitation. *Social Science & Medicine*, 71, 1489-1497.
- Richter, K. P., & Bammer, G. (2000). A hierarchy of strategies heroin-using mothers employ to reduce harm to their children. *Journal of Substance Abuse Treatment*, 19, 403-413.
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method, Research*. London, UK: Sage Publications.
- Smith, J. A., & Osborn, M. (2008). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative psychology: a practical guide to research methods*. London, UK: Sage Publications.

- Söderström, K., & Skårderud, F. (2013). The good, the bad, and the invisible father: a phenomenological study of fatherhood in men with substance use disorder. *Fathering: A Journal of Theory, Research & Practice about Men as Fathers*, 11, 31-51.
- Solis, J. M., Shadur, J. M., Burns, A. R., & Hussong, A. M. (2012). Understanding the Diverse Needs of Children Whose Parents Abuse Substances. *Current Drug Abuse Reviews*, 5, 135-147.
- Stover, C. S., & Coates, E. E. (2016). The Relationship of Reflective Functioning to Parent Child Interactions in a Sample of Fathers With Concurrent Intimate Partner Violence Perpetration and Substance Abuse Problems. *Journal of Family Violence*, 31, 433-442.
- Stover, C. S., & Kiselica, A. (2014). An initial examination of the association of reflective functioning to parenting of fathers. *Infant Mental Health Journal*, 35, 452-461.
- Stover, C. S., & Spink, A. (2012). Affective awareness in parenting of fathers with co-occurring substance abuse and intimate partner violence. *Advances in Dual Diagnosis*, 5, 74-85 12p.
- Tay, L., & Diener, E. (2011). Needs and subjective well-being around the world. *Journal of personality and social psychology*, 101, 354.
- Taylor, M. (2012). Problem drug use and fatherhood. Dissertation: University of Glasgow.
- Templeton, L., Zohhadi, S., Galvani, S., & Velleman, R. (2006). "Looking Beyond Risk" *Parental Substance Misuse: Scoping Study*. Edinburgh: Scottish Executive Substance Misuse Research Programme.
- Torres, M., Sng, R., & Deane, F. P. (2015). Establishing a Parenting Program for Fathers in Substance Abuse Treatment. *Australian & New Zealand Journal of Family Therapy*, 36, 273-288.
- Whittaker, A. (2008). The construction of fatherhood within the context of problem drug use. Dissertation: University of Dundee.
- Yardley, L. (2008). Demonstrating validity in qualitative psychology. In J. A. Smith (Ed.), *Qualitative Psychology: A practical guide to research methods*. London, UK: Sage Publications.

## **Appendix**

**Appendix A: Journal of Affective Disorders author guidelines**

**Appendix B: Journal of International Drug Policy author guidelines**

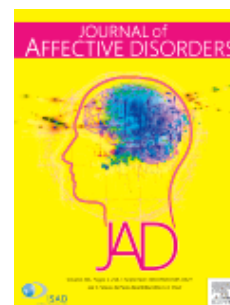
**Appendix C: Ethics approvals for empirical study**

**Appendix D: nVivo theme excerpt 'Hands-on Father'**

## **Appendix A: Journal of Affective Disorders author guidelines**

## TABLE OF CONTENTS

•	<b>Description</b>	<b>p.1</b>
•	<b>Audience</b>	<b>p.1</b>
•	<b>Impact Factor</b>	<b>p.1</b>
•	<b>Abstracting and Indexing</b>	<b>p.1</b>
•	<b>Editorial Board</b>	<b>p.2</b>
•	<b>Guide for Authors</b>	<b>p.4</b>



ISSN: 0165-0327

## DESCRIPTION

*The Journal of Affective Disorders* publishes papers concerned with affective disorders in the widest sense: depression, mania, mood spectrum, emotions and personality, anxiety and stress. It is interdisciplinary and aims to bring together different approaches for a diverse readership. Top quality papers will be accepted dealing with any aspect of affective disorders, including neuroimaging, cognitive neurosciences, genetics, molecular biology, experimental and clinical neurosciences, pharmacology, neuroimmunoendocrinology, intervention and treatment trials.

## AUDIENCE

Journal of Affective Disorders is interdisciplinary and aims to bring together different approaches and fields including biochemistry, pharmacology, endocrinology, genetics, statistics, epidemiology, psychodynamics, classification, clinical studies and studies of all types of treatment for a diverse readership.

## IMPACT FACTOR

2015: 3.570 © Thomson Reuters Journal Citation Reports 2016

## ABSTRACTING AND INDEXING

BIOSIS  
Current Contents/Life Sciences  
MEDLINE®  
Informaticus  
EMBASE  
Pascal et Francis (INST-CNRS)  
PsycINFO Psychological Abstracts  
SIIC Data Bases  
Scopus

## GUIDE FOR AUTHORS

---

### Description

*The Journal of Affective Disorders* publishes papers concerned with **affective disorders** in the widest sense: **depression, mania, anxiety and panic**. It is interdisciplinary and aims to bring together different approaches for a diverse readership. High quality papers will be accepted dealing with any aspect of affective disorders, including biochemistry, pharmacology, endocrinology, genetics, statistics, epidemiology, psychodynamics, classification, clinical studies and studies of all types of treatment.

### BEFORE YOU BEGIN

#### Ethics in publishing

Please see our information pages on [Ethics in publishing](#) and [Ethical guidelines for journal publication](#).

#### Ethical Considerations

Authors of reports on human studies, especially those involving placebo, symptom provocation, drug discontinuation, or patients with disorders that may impair decision-making capability, should consider the ethical issues related to the work presented and include (in the Methods and Materials section of their manuscript) detailed information on the informed consent process, including the method or methods used to assess the subject's capacity to give informed consent, and safeguards included in the study design for protection of human subjects. Specifically, authors should consider all ethical issues relevant to their research, and briefly address each of these in their reports. When relevant patient follow-up data are available, this should also be reported. Specifically, investigators reporting on research involving human subjects or animals must have prior approval from an institutional review board. This approval should be mentioned in the methods section of the manuscript. In countries where institutional review boards are not available; the authors must include a statement that research was conducted in accordance with the Helsinki Declaration as revised 1989. All studies involving animals must state that the authors followed the guidelines for the use and care of laboratory animals of the author's institution or the National Research Council or any national law pertaining to animal research care.

#### Declaration of interest

All authors must disclose any financial and personal relationships with other people or organizations that could inappropriately influence (bias) their work. Examples of potential conflicts of interest include employment, consultancies, stock ownership, honoraria, paid expert testimony, patent applications/registrations, and grants or other funding. If there are no conflicts of interest then please state this: 'Conflicts of interest: none'. [More information](#).

#### Contributors

Each author is required to declare his or her individual contribution to the article: all authors must have materially participated in the research and/or article preparation, so roles for all authors should be described. The statement that all authors have approved the final article should be true and included in the disclosure.

#### Changes to authorship

Authors are expected to consider carefully the list and order of authors **before** submitting their manuscript and provide the definitive list of authors at the time of the original submission. Any addition, deletion or rearrangement of author names in the authorship list should be made only **before** the manuscript has been accepted and only if approved by the journal Editor. To request such a change, the Editor must receive the following from the **corresponding author**: (a) the reason for the change in author list and (b) written confirmation (e-mail, letter) from all authors that they agree with the addition, removal or rearrangement. In the case of addition or removal of authors, this includes confirmation from the author being added or removed.

Only in exceptional circumstances will the Editor consider the addition, deletion or rearrangement of authors **after** the manuscript has been accepted. While the Editor considers the request, publication of the manuscript will be suspended. If the manuscript has already been published in an online issue, any requests approved by the Editor will result in a corrigendum.

## Copyright

Upon acceptance of an article, authors will be asked to complete a 'Journal Publishing Agreement' (see [more information](#) on this). An e-mail will be sent to the corresponding author confirming receipt of the manuscript together with a 'Journal Publishing Agreement' form or a link to the online version of this agreement.

Subscribers may reproduce tables of contents or prepare lists of articles including abstracts for internal circulation within their institutions. [Permission](#) of the Publisher is required for resale or distribution outside the institution and for all other derivative works, including compilations and translations. If excerpts from other copyrighted works are included, the author(s) must obtain written permission from the copyright owners and credit the source(s) in the article. Elsevier has [preprinted forms](#) for use by authors in these cases.

For open access articles: Upon acceptance of an article, authors will be asked to complete an 'Exclusive License Agreement' ([more information](#)). Permitted third party reuse of open access articles is determined by the author's choice of [user license](#).

## Author rights

As an author you (or your employer or institution) have certain rights to reuse your work. [More information](#).

*Elsevier supports responsible sharing*

Find out how you can [share your research](#) published in Elsevier journals.

## Role of the funding source

You are requested to identify who provided financial support for the conduct of the research and/or preparation of the article and to briefly describe the role of the sponsor(s), if any, in study design; in the collection, analysis and interpretation of data; in the writing of the report; and in the decision to submit the article for publication. If the funding source(s) had no such involvement then this should be stated.

*Funding body agreements and policies*

Elsevier has established a number of agreements with funding bodies which allow authors to comply with their funder's open access policies. Some funding bodies will reimburse the author for the Open Access Publication Fee. Details of [existing agreements](#) are available online.

After acceptance, open access papers will be published under a noncommercial license. For authors requiring a commercial CC BY license, you can apply after your manuscript is accepted for publication.

## Open access

This journal offers authors a choice in publishing their research:

### Open access

- Articles are freely available to both subscribers and the wider public with permitted reuse.
- An open access publication fee is payable by authors or on their behalf, e.g. by their research funder or institution.

### Subscription

- Articles are made available to subscribers as well as developing countries and patient groups through our [universal access programs](#).
- No open access publication fee payable by authors.

Regardless of how you choose to publish your article, the journal will apply the same peer review criteria and acceptance standards.

For open access articles, permitted third party (re)use is defined by the following [Creative Commons user licenses](#):

*Creative Commons Attribution-NonCommercial-NoDerivs (CC BY-NC-ND)*

For non-commercial purposes, lets others distribute and copy the article, and to include in a collective work (such as an anthology), as long as they credit the author(s) and provided they do not alter or modify the article.

The open access publication fee for this journal is **USD 3000**, excluding taxes. Learn more about Elsevier's pricing policy: <https://www.elsevier.com/openaccesspricing>.



### *Green open access*

Authors can share their research in a variety of different ways and Elsevier has a number of green open access options available. We recommend authors see our [green open access page](#) for further information. Authors can also self-archive their manuscripts immediately and enable public access from their institution's repository after an embargo period. This is the version that has been accepted for publication and which typically includes author-incorporated changes suggested during submission, peer review and in editor-author communications. Embargo period: For subscription articles, an appropriate amount of time is needed for journals to deliver value to subscribing customers before an article becomes freely available to the public. This is the embargo period and it begins from the date the article is formally published online in its final and fully citable form.

This journal has an embargo period of 12 months.

### *Elsevier Publishing Campus*

The Elsevier Publishing Campus ([www.publishingcampus.com](http://www.publishingcampus.com)) is an online platform offering free lectures, interactive training and professional advice to support you in publishing your research. The College of Skills training offers modules on how to prepare, write and structure your article and explains how editors will look at your paper when it is submitted for publication. Use these resources, and more, to ensure that your submission will be the best that you can make it.

### *Language (usage and editing services)*

Please write your text in good English (American or British usage is accepted, but not a mixture of these). Authors who feel their English language manuscript may require editing to eliminate possible grammatical or spelling errors and to conform to correct scientific English may wish to use the [English Language Editing service](#) available from Elsevier's WebShop.

### **Submission**

Our online submission system guides you stepwise through the process of entering your article details and uploading your files. The system converts your article files to a single PDF file used in the peer-review process. Editable files (e.g., Word, LaTeX) are required to typeset your article for final publication. All correspondence, including notification of the Editor's decision and requests for revision, is sent by e-mail.

### **Manuscript Submission**

The *Journal of Affective Disorders* now proceeds totally online via an electronic submission system. Mail submissions will no longer be accepted. By accessing the online submission system, [http://www.evise.com/evise/faces/pages/navigation/NavController.jspx?JRNL\\_ACR=JAD](http://www.evise.com/evise/faces/pages/navigation/NavController.jspx?JRNL_ACR=JAD), you will be guided stepwise through the creation and uploading of the various files. When submitting a manuscript online, authors need to provide an electronic version of their manuscript and any accompanying figures and tables.

The author should select from a list of scientific classifications, which will be used to help the editors select reviewers with appropriate expertise, and an article type for their manuscript. Once the uploading is done, the system automatically generates an electronic (PDF) proof, which is then used for reviewing. All correspondence, including the Editor's decision and request for revisions, will be processed through the system and will reach the corresponding author by e-mail.

Once a manuscript has successfully been submitted via the online submission system authors may track the status of their manuscript using the online submission system (details will be provided by e-mail). If your manuscript is accepted by the journal, subsequent tracking facilities are available on Elsevier's Author Gateway, using the unique reference number provided by Elsevier and corresponding author name (details will be provided by e-mail).

Authors may send queries concerning the submission process or journal procedures to our Editors-in-Chief

**Paolo Brambilla: [paolo.brambilla1@unimi.it](mailto:paolo.brambilla1@unimi.it) or Jair Soares: [Jair.C.Souares@uth.tmc.edu](mailto:Jair.C.Souares@uth.tmc.edu).**

Please submit your article via [http://www.evise.com/evise/faces/pages/navigation/NavController.jspx?JRNL\\_ACR=JAD](http://www.evise.com/evise/faces/pages/navigation/NavController.jspx?JRNL_ACR=JAD)

### *Types of Papers*

The Journal primarily publishes:

Full-Length Research Papers (up to 5000 words, excluding references and up to 6 tables/figures)

Review Articles and Meta-analyses (up to 8000 words, excluding references and up to 10 tables/figures)

Short Communications (up to 2000 words, 20 references, 2 tables/figures)

Correspondence (up to 1000 words, 10 references, 1 table/figure).

At the discretion of the accepting Editor-in-Chief, and/or based on reviewer feedback, authors may be allowed fewer or more than these guidelines.

#### *Retraction Policy*

It is a general principle of scholarly communication that the editor of a learned journal is solely and independently responsible for deciding which articles submitted to the journal shall be published. In making this decision the editor is guided by policies of the journal's editorial board and constrained by such legal requirements in force regarding libel, copyright infringement and plagiarism. Although electronic methods are available to detect plagiarism and duplicate publications, editors nonetheless rely in large part on the integrity of authors to fulfil their responsibilities within the requirements of publication ethics and only submit work to which they can rightfully claim authorship and which has not previously been published.

An outcome of this principle is the importance of the scholarly archive as a permanent, historic record of the transactions of scholarship. Articles that have been published shall remain extant, exact and unaltered as far as is possible. However, very occasionally circumstances may arise where an article is published that must later be retracted or even removed. Such actions must not be undertaken lightly and can only occur under exceptional circumstances, such as:

- Article Withdrawal: Only used for Articles in Press which represent early versions of articles and sometimes contain errors, or may have been accidentally submitted twice. Occasionally, but less frequently, the articles may represent infringements of professional ethical codes, such as multiple submission, bogus claims of authorship, plagiarism, fraudulent use of data or the like.
- Article Retraction: Infringements of professional ethical codes, such as multiple submission, bogus claims of authorship, plagiarism, fraudulent use of data or the like. Occasionally a retraction will be used to correct errors in submission or publication.
- Article Removal: Legal limitations upon the publisher, copyright holder or author(s).
- Article Replacement: Identification of false or inaccurate data that, if acted upon, would pose a serious health risk.

For the full policy and further details, please refer <http://www.elsevier.com/about/publishing-guidelines/policies/article-withdrawal>

#### *Referees*

Please submit the names and institutional e-mail addresses of several potential referees. For more details, visit our [Support site](#). Note that the editor retains the sole right to decide whether or not the suggested reviewers are used.

#### **Preparation of Manuscripts**

Articles should be in English. The title page should appear as a separate sheet bearing title (without article type), author names and affiliations, and a footnote with the corresponding author's full contact information, including address, telephone and fax numbers, and e-mail address (failure to include an e-mail address can delay processing of the manuscript).

Papers should be divided into sections headed by a caption (e.g., Introduction, Methods, Results, Discussion). A structured abstract of no more than 250 words should appear on a separate page with the following headings and order: Background, Methods, Results, Limitations, Conclusions (which should contain a statement about the clinical relevance of the research). A list of three to six key words should appear under the abstract. **Authors should note that the 'limitations' section both in the discussion of the paper AND IN A STRUCTURED ABSTRACT are essential. Failure to include it may delay in processing the paper, decision making and final publication.**

#### **Figures and Photographs**

Figures and Photographs of good quality should be submitted online as a separate file. Please use a lettering that remains clearly readable even after reduction to about 66%. For every figure or photograph, a legend should be provided. All authors wishing to use illustrations already published must first obtain the permission of the author and publisher and/or copyright holders and give precise reference to the original work. This permission must include the right to publish in electronic media.

## Tables

Tables should be numbered consecutively with Arabic numerals and must be cited in the text in sequence. Each table, with an appropriate brief legend, comprehensible without reference to the text, should be typed on a separate page and uploaded online. Tables should be kept as simple as possible and wherever possible a graphical representation used instead. Table titles should be complete but brief. Information other than that defining the data should be presented as footnotes.

Please refer to the generic Elsevier artwork instructions: <http://authors.elsevier.com/artwork/jad>.

## Preparation of supplementary data

Elsevier accepts electronic supplementary material to support and enhance your scientific research. Supplementary files offer the author additional possibilities to publish supporting applications, movies, animation sequences, high-resolution images, background datasets, sound clips and more.

Supplementary files supplied will be published online alongside the electronic version of your article in Elsevier web products, including ScienceDirect: <http://www.sciencedirect.com>. In order to ensure that your submitted material is directly usable, please ensure that data is provided in one of our recommended file formats. Authors should submit the material in electronic format together with the article and supply a concise and descriptive caption for each file. For more detailed instructions please visit our Author Gateway at: <http://www.elsevier.com/authors>

## AudioSlides

The journal encourages authors to create an AudioSlides presentation with their published article. AudioSlides are brief, webinar-style presentations that are shown next to the online article on ScienceDirect. This gives authors the opportunity to summarize their research in their own words and to help readers understand what the paper is about. More information and examples are available at <http://www.elsevier.com/audioslides>. Authors of this journal will automatically receive an invitation e-mail to create an AudioSlides presentation after acceptance of their paper.

## Colour reproduction

The Journal of Affective Disorders is now also included in a new initiative from Elsevier: 'Colourful e-Products'. Through this initiative, figures that appear in black & white in print can appear in colour, online, in ScienceDirect at <http://www.sciencedirect.com>.

There is no extra charge for authors who participate.

For colour reproduction in print, you will receive information regarding the costs from Elsevier after receipt of your accepted article. Please indicate your preference for colour in print or on the Web only. Because of technical complications which can arise by converting colour figures to "grey scale" (for the printed version should you not opt for colour in print) please submit in addition usable black and white versions of all the colour illustrations. For further information on the preparation of electronic artwork, please see <http://authors.elsevier.com/artwork/jad>.

### *Use of word processing software*

It is important that the file be saved in the native format of the word processor used. The text should be in single-column format. Keep the layout of the text as simple as possible. Most formatting codes will be removed and replaced on processing the article. In particular, do not use the word processor's options to justify text or to hyphenate words. However, do use bold face, italics, subscripts, superscripts etc. When preparing tables, if you are using a table grid, use only one grid for each individual table and not a grid for each row. If no grid is used, use tabs, not spaces, to align columns. The electronic text should be prepared in a way very similar to that of conventional manuscripts (see

also the [Guide to Publishing with Elsevier](#)). Note that source files of figures, tables and text graphics will be required whether or not you embed your figures in the text. See also the section on Electronic artwork.

To avoid unnecessary errors you are strongly advised to use the 'spell-check' and 'grammar-check' functions of your word processor.

### **Abstract**

A concise and factual abstract is required. The abstract should state briefly the purpose of the research, the principal results and major conclusions. An abstract is often presented separately from the article, so it must be able to stand alone. For this reason, References should be avoided, but if essential, then cite the author(s) and year(s). Also, non-standard or uncommon abbreviations should be avoided, but if essential they must be defined at their first mention in the abstract itself.

#### *Graphical abstract*

Although a graphical abstract is optional, its use is encouraged as it draws more attention to the online article. The graphical abstract should summarize the contents of the article in a concise, pictorial form designed to capture the attention of a wide readership. Graphical abstracts should be submitted as a separate file in the online submission system. Image size: Please provide an image with a minimum of 531 × 1328 pixels (h × w) or proportionally more. The image should be readable at a size of 5 × 13 cm using a regular screen resolution of 96 dpi. Preferred file types: TIFF, EPS, PDF or MS Office files. You can view [Example Graphical Abstracts](#) on our information site.

Authors can make use of Elsevier's Illustration and Enhancement service to ensure the best presentation of their images and in accordance with all technical requirements: [Illustration Service](#).

#### *Highlights*

Highlights are mandatory for this journal. They consist of a short collection of bullet points that convey the core findings of the article and should be submitted in a separate editable file in the online submission system. Please use 'Highlights' in the file name and include 3 to 5 bullet points (maximum 85 characters, including spaces, per bullet point). You can view [example Highlights](#) on our information site.

### **Keywords**

Immediately after the abstract, provide a maximum of 6 keywords, using American spelling and avoiding general and plural terms and multiple concepts (avoid, for example, 'and', 'of'). Be sparing with abbreviations: only abbreviations firmly established in the field may be eligible. These keywords will be used for indexing purposes.

#### *Abbreviations*

Define abbreviations that are not standard in this field in a footnote to be placed on the first page of the article. Such abbreviations that are unavoidable in the abstract must be defined at their first mention there, as well as in the footnote. Ensure consistency of abbreviations throughout the article.

#### *Acknowledgements*

Collate acknowledgements in a separate section at the end of the article before the references and do not, therefore, include them on the title page, as a footnote to the title or otherwise. List here those individuals who provided help during the research (e.g., providing language help, writing assistance or proof reading the article, etc.).

#### *Formatting of funding sources*

List funding sources in this standard way to facilitate compliance to funder's requirements:

Funding: This work was supported by the National Institutes of Health [grant numbers xxxx, yyyy]; the Bill & Melinda Gates Foundation, Seattle, WA [grant number zzzz]; and the United States Institutes of Peace [grant number aaaa].

It is not necessary to include detailed descriptions on the program or type of grants and awards. When funding is from a block grant or other resources available to a university, college, or other research institution, submit the name of the institute or organization that provided the funding.

If no funding has been provided for the research, please include the following sentence:

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

### *Nomenclature and units*

Follow internationally accepted rules and conventions: use the international system of units (SI). If other quantities are mentioned, give their equivalent in SI. You are urged to consult [IUPAC: Nomenclature of Organic Chemistry](#) for further information.

### *Math formulae*

Please submit math equations as editable text and not as images. Present simple formulae in line with normal text where possible and use the solidus (/) instead of a horizontal line for small fractional terms, e.g., X/Y. In principle, variables are to be presented in italics. Powers of e are often more conveniently denoted by exp. Number consecutively any equations that have to be displayed separately from the text (if referred to explicitly in the text).

### *Footnotes*

Footnotes should be used sparingly. Number them consecutively throughout the article. Many word processors can build footnotes into the text, and this feature may be used. Otherwise, please indicate the position of footnotes in the text and list the footnotes themselves separately at the end of the article. Do not include footnotes in the Reference list.

## **Artwork**

### *Electronic artwork*

#### *General points*

- Make sure you use uniform lettering and sizing of your original artwork.
- Embed the used fonts if the application provides that option.
- Aim to use the following fonts in your illustrations: Arial, Courier, Times New Roman, Symbol, or use fonts that look similar.
- Number the illustrations according to their sequence in the text.
- Use a logical naming convention for your artwork files.
- Provide captions to illustrations separately.
- Size the illustrations close to the desired dimensions of the published version.
- Submit each illustration as a separate file.

A detailed [guide on electronic artwork](#) is available.

**You are urged to visit this site; some excerpts from the detailed information are given here.**

#### *Formats*

If your electronic artwork is created in a Microsoft Office application (Word, PowerPoint, Excel) then please supply 'as is' in the native document format.

Regardless of the application used other than Microsoft Office, when your electronic artwork is finalized, please 'Save as' or convert the images to one of the following formats (note the resolution requirements for line drawings, halftones, and line/halftone combinations given below):

EPS (or PDF): Vector drawings, embed all used fonts.

TIFF (or JPEG): Color or grayscale photographs (halftones), keep to a minimum of 300 dpi.

TIFF (or JPEG): Bitmapped (pure black & white pixels) line drawings, keep to a minimum of 1000 dpi.

TIFF (or JPEG): Combinations bitmapped line/half-tone (color or grayscale), keep to a minimum of 500 dpi.

#### **Please do not:**

- Supply files that are optimized for screen use (e.g., GIF, BMP, PICT, WPG); these typically have a low number of pixels and limited set of colors;
- Supply files that are too low in resolution;
- Submit graphics that are disproportionately large for the content.

### *Color artwork*

Please make sure that artwork files are in an acceptable format (TIFF (or JPEG), EPS (or PDF), or MS Office files) and with the correct resolution. If, together with your accepted article, you submit usable color figures then Elsevier will ensure, at no additional charge, that these figures will appear in color online (e.g., ScienceDirect and other sites) regardless of whether or not these illustrations are reproduced in color in the printed version. **For color reproduction in print, you will receive information regarding the costs from Elsevier after receipt of your accepted article.** Please indicate your preference for color: in print or online only. [Further information on the preparation of electronic artwork.](#)



### *Illustration services*

Elsevier's [WebShop](#) offers Illustration Services to authors preparing to submit a manuscript but concerned about the quality of the images accompanying their article. Elsevier's expert illustrators can produce scientific, technical and medical-style images, as well as a full range of charts, tables and graphs. Image 'polishing' is also available, where our illustrators take your image(s) and improve them to a professional standard. Please visit the website to find out more.

### **Tables**

Please submit tables as editable text and not as images. Tables can be placed either next to the relevant text in the article, or on separate page(s) at the end. Number tables consecutively in accordance with their appearance in the text and place any table notes below the table body. Be sparing in the use of tables and ensure that the data presented in them do not duplicate results described elsewhere in the article. Please avoid using vertical rules.

### **References**

#### *Citation in text*

Please ensure that every reference cited in the text is also present in the reference list (and vice versa). Any references cited in the abstract must be given in full. Unpublished results and personal communications are not recommended in the reference list, but may be mentioned in the text. If these references are included in the reference list they should follow the standard reference style of the journal and should include a substitution of the publication date with either 'Unpublished results' or 'Personal communication'. Citation of a reference as 'in press' implies that the item has been accepted for publication.

#### *Reference management software*

Most Elsevier journals have their reference template available in many of the most popular reference management software products. These include all products that support [Citation Style Language styles](#), such as [Mendeley](#) and [Zotero](#), as well as [EndNote](#). Using the word processor plug-ins from these products, authors only need to select the appropriate journal template when preparing their article, after which citations and bibliographies will be automatically formatted in the journal's style. If no template is yet available for this journal, please follow the format of the sample references and citations as shown in this Guide.

Users of Mendeley Desktop can easily install the reference style for this journal by clicking the following link:

<http://open.mendeley.com/use-citation-style/journal-of-affective-disorders>

When preparing your manuscript, you will then be able to select this style using the Mendeley plug-ins for Microsoft Word or LibreOffice.

#### *Reference style*

*Text:* All citations in the text should refer to:

1. *Single author:* the author's name (without initials, unless there is ambiguity) and the year of publication;
2. *Two authors:* both authors' names and the year of publication;
3. *Three or more authors:* first author's name followed by 'et al.' and the year of publication.

Citations may be made directly (or parenthetically). Groups of references should be listed first alphabetically, then chronologically.

Examples: 'as demonstrated (Allan, 2000a, 2000b, 1999; Allan and Jones, 1999). Kramer et al. (2010) have recently shown ....'

*List:* References should be arranged first alphabetically and then further sorted chronologically if necessary. More than one reference from the same author(s) in the same year must be identified by the letters 'a', 'b', 'c', etc., placed after the year of publication.

#### *Examples:*

Reference to a journal publication:

Van der Geer, J., Hanraads, J.A.J., Lupton, R.A., 2010. The art of writing a scientific article. *J. Sci. Commun.* 163, 51–59.

Reference to a book:

Strunk Jr., W., White, E.B., 2000. *The Elements of Style*, fourth ed. Longman, New York.

Reference to a chapter in an edited book:

Mettam, G.R., Adams, L.B., 2009. How to prepare an electronic version of your article, in: Jones, B.S., Smith, R.Z. (Eds.), *Introduction to the Electronic Age*. E-Publishing Inc., New York, pp. 281–304.

Reference to a website:

Cancer Research UK, 1975. Cancer statistics reports for the UK. <http://www.cancerresearchuk.org/aboutcancer/statistics/cancerstatsreport/> (accessed 13.03.03).

### **Video**

Elsevier accepts video material and animation sequences to support and enhance your scientific research. Authors who have video or animation files that they wish to submit with their article are strongly encouraged to include links to these within the body of the article. This can be done in the same way as a figure or table by referring to the video or animation content and noting in the body text where it should be placed. All submitted files should be properly labeled so that they directly relate to the video file's content. In order to ensure that your video or animation material is directly usable, please provide the files in one of our recommended file formats with a preferred maximum size of 150 MB. Video and animation files supplied will be published online in the electronic version of your article in Elsevier Web products, including [ScienceDirect](#). Please supply 'stills' with your files: you can choose any frame from the video or animation or make a separate image. These will be used instead of standard icons and will personalize the link to your video data. For more detailed instructions please visit our [video instruction pages](#). Note: since video and animation cannot be embedded in the print version of the journal, please provide text for both the electronic and the print version for the portions of the article that refer to this content.

### **Supplementary material**

Supplementary material can support and enhance your scientific research. Supplementary files offer the author additional possibilities to publish supporting applications, high-resolution images, background datasets, sound clips and more. Please note that such items are published online exactly as they are submitted; there is no typesetting involved (supplementary data supplied as an Excel file or as a PowerPoint slide will appear as such online). Please submit the material together with the article and supply a concise and descriptive caption for each file. If you wish to make any changes to supplementary data during any stage of the process, then please make sure to provide an updated file, and do not annotate any corrections on a previous version. Please also make sure to switch off the 'Track Changes' option in any Microsoft Office files as these will appear in the published supplementary file(s). For more detailed instructions please visit our [artwork instruction pages](#).

### **AudioSlides**

The journal encourages authors to create an AudioSlides presentation with their published article. AudioSlides are brief, webinar-style presentations that are shown next to the online article on ScienceDirect. This gives authors the opportunity to summarize their research in their own words and to help readers understand what the paper is about. [More information and examples are available](#). Authors of this journal will automatically receive an invitation e-mail to create an AudioSlides presentation after acceptance of their paper.

### **3D neuroimaging**

You can enrich your online articles by providing 3D neuroimaging data in NIfTI format. This will be visualized for readers using the interactive viewer embedded within your article, and will enable them to: browse through available neuroimaging datasets; zoom, rotate and pan the 3D brain reconstruction; cut through the volume; change opacity and color mapping; switch between 3D and 2D projected views; and download the data. The viewer supports both single (.nii) and dual (.hdr and .img) NIfTI file formats. Recommended size of a single uncompressed dataset is maximum 150 MB. Multiple datasets can be submitted. Each dataset will have to be zipped and uploaded to the online submission system via the '3D neuroimaging data' submission category. Please provide a short informative description for each dataset by filling in the 'Description' field when uploading a dataset. Note: all datasets will be available for downloading from the online article on ScienceDirect. If you have concerns about your data being downloadable, please provide a video instead. [More information](#).

### **Submission checklist**

The following list will be useful during the final checking of an article prior to sending it to the journal for review. Please consult this Guide for Authors for further details of any item.

#### **Ensure that the following items are present:**

One author has been designated as the corresponding author with contact details:

- E-mail address
- Full postal address

All necessary files have been uploaded, and contain:

- Keywords
- All figure captions

- All tables (including title, description, footnotes)

Further considerations

- Manuscript has been 'spell-checked' and 'grammar-checked'
- References are in the correct format for this journal
- All references mentioned in the Reference list are cited in the text, and vice versa
- Permission has been obtained for use of copyrighted material from other sources (including the Internet)

Printed version of figures (if applicable) in color or black-and-white

- Indicate clearly whether or not color or black-and-white in print is required.

For any further information please visit our [Support Center](#).

## **AFTER ACCEPTANCE**

### **Author disclosure**

Funding body agreements and policies Elsevier has established agreements and developed policies to allow authors whose articles appear in journals published by Elsevier, to comply with potential manuscript archiving requirements as specified as conditions of their grant awards. To learn more about existing agreements and policies please visit <http://www.elsevier.com/fundingbodies>

The second aspect of the Journal's new policy concerns the Conflict of Interest. ALL authors are requested to disclose any actual or potential conflict of interest including any financial, personal or other relationships with other people or organizations within three (3) years of beginning the work submitted that could inappropriately influence, or be perceived to influence, their work.

Examples of potential conflicts of interest which should be disclosed include employment, consultancies, stock ownership (except for personal investment purposes equal to the lesser of one percent (1%) or USD 5000), honoraria, paid expert testimony, patent applications, registrations, and grants. If there are no conflicts of interest, authors should state that there are none.

eg, Author Y owns shares in pharma company A. Author X and Z have consulted for pharma company B. All other authors declare that they have no conflicts of interest.

Finally, before the references, the Journal will publish Acknowledgements, in a separate section, and not as a footnote on the title page.

eg, We thank Mr A, who kindly provided the data necessary for our analysis, and Miss B, who assisted with the preparation and proof-reading of the manuscript.

The submitting author is also required to make a brief statement concerning each named author's contributions to the paper under the heading Contributors. This statement is for editorial purposes only and will not be published with the article.

eg, Author X designed the study and wrote the protocol. Author Y managed the literature searches and analyses. Authors X and Z undertook the statistical analysis, and author W wrote the first draft of the manuscript. All authors contributed to and have approved the final manuscript.

NB. During the online submission process the author will be prompted to upload these four mandatory author disclosures as separate items. They will be automatically incorporated in the PDF builder of the online submission system. Please do not include in the main manuscripts.

### **Copyright Transfer**

Upon acceptance of an article, you will be asked to transfer copyright (for more information on copyright see <http://authors.elsevier.com/journal/jad>). This transfer will ensure the widest possible dissemination of information. If excerpts from other copyrighted works are included in the submission, the author(s) must obtain written permission from the copyright owners and credit the source(s) in the article. Elsevier has preprinted forms for use by authors in these cases: contact Elsevier's Rights Department, Philadelphia, PA, USA: phone (+1) 215 238 7869, fax (+1) 215 238 2239, e-mail: [healthpermissions@elsevier.com](mailto:healthpermissions@elsevier.com).

Requests for materials from other Elsevier publications may also be completed on-line via the Elsevier homepage <http://www.elsevier.com/locate/permissions>



## Proofs

One set of page proofs (as PDF files) will be sent by e-mail to the corresponding author (if we do not have an e-mail address then paper proofs will be sent by post) or, a link will be provided in the e-mail so that authors can download the files themselves. Elsevier now provides authors with PDF proofs which can be annotated; for this you will need to [download the free Adobe Reader](#), version 9 (or higher). Instructions on how to annotate PDF files will accompany the proofs (also given online). The exact system requirements are given at the [Adobe site](#).

If you do not wish to use the PDF annotations function, you may list the corrections (including replies to the Query Form) and return them to Elsevier in an e-mail. Please list your corrections quoting line number. If, for any reason, this is not possible, then mark the corrections and any other comments (including replies to the Query Form) on a printout of your proof and scan the pages and return via e-mail. Please use this proof only for checking the typesetting, editing, completeness and correctness of the text, tables and figures. Significant changes to the article as accepted for publication will only be considered at this stage with permission from the Editor. We will do everything possible to get your article published quickly and accurately. It is important to ensure that all corrections are sent back to us in one communication: please check carefully before replying, as inclusion of any subsequent corrections cannot be guaranteed. Proofreading is solely your responsibility.

## Reprints

The corresponding author, at no cost, will be provided with a PDF file of the article via e-mail. The PDF file is a watermarked version of the published article and includes a cover sheet with the journal cover image and a disclaimer outlining the terms and conditions of use. There are no page charges.

Author enquiries: For enquiries relating to the submission of articles please visit Elsevier's Author Gateway at <http://authors.elsevier.com/journal/jad>. The Author Gateway also provides the facility to track accepted articles and set up e-mail alerts to inform you of when an article's status has changed, as well as detailed artwork guidelines, copyright information, frequently asked questions and more. Contact details for questions arising after acceptance of an article, especially those relating to proofs, are provided after registration of an article for publication.

## Offprints

The corresponding author will, at no cost, receive a customized [Share Link](#) providing 50 days free access to the final published version of the article on [ScienceDirect](#). The Share Link can be used for sharing the article via any communication channel, including email and social media. For an extra charge, paper offprints can be ordered via the offprint order form which is sent once the article is accepted for publication. Both corresponding and co-authors may order offprints at any time via Elsevier's [Webshop](#). Corresponding authors who have published their article open access do not receive a Share Link as their final published version of the article is available open access on ScienceDirect and can be shared through the article DOI link.

## AUTHOR INQUIRIES

[Track your submitted article](#)

[Track your accepted article](#)

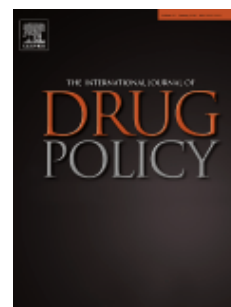
You are also welcome to contact the [Elsevier Support Center](#).

© Copyright 2014 Elsevier | <http://www.elsevier.com>

## **Appendix B: International Journal of Drug Policy author guidelines**

### TABLE OF CONTENTS

•	<b>Description</b>	<b>p.1</b>
•	<b>Audience</b>	<b>p.1</b>
•	<b>Impact Factor</b>	<b>p.1</b>
•	<b>Abstracting and Indexing</b>	<b>p.2</b>
•	<b>Editorial Board</b>	<b>p.2</b>
•	<b>Guide for Authors</b>	<b>p.4</b>



ISSN: 0955-3959

### DESCRIPTION

*The International Journal of Drug Policy* provides a forum for the dissemination of current research, reviews, debate, and critical analysis on **drug use** and **drug policy** in a global context. It seeks to publish material on the social, political, legal, and health contexts of **psychoactive substance use**, both licit and illicit. The journal is particularly concerned to explore the effects of drug policy and practice on drug-using behaviour and its **health** and **social consequences**. It is the policy of the journal to represent a wide range of material on drug-related matters from around the world.

*The International Journal of Drug Policy* is ranked 4th out of 36 journals in the SUBSTANCE ABUSE category in the 2014 Journal Citation Reports, published by Thomson Reuters, and has an Impact Factor of 3.191.

Please submit your article via <http://ees.elsevier.com/drugpo/>

**Electronic usage** An increasing number of readers access the journal online via [ScienceDirect](#), one of the world's most advanced web delivery systems for scientific, technical and medical information, and through the journal's web site, [ijdp.org](http://ijdp.org).

2014 Usage:

**23,046** average monthly article downloads on [ScienceDirect](#)

**14,889** average monthly pageviews on [ijdp.org](http://ijdp.org)

### AUDIENCE

Governmental organizations, university libraries, hospital libraries, research institutions, sociologists, nurses, police departments, addiction centers, educationists and politicians.

### IMPACT FACTOR

2014: 3.191 © Thomson Reuters Journal Citation Reports 2015

## GUIDE FOR AUTHORS

---

### INTRODUCTION

The *International Journal of Drug Policy* is a bimonthly multidisciplinary journal for original research, reviews, debate, and critical analysis on the epidemiology and social contexts of drug use and drug policy in a global context. The journal seeks to explore the health and social effects of drug use and drug policy, in relation to both licit and illicit substances. The *International Journal of Drug Policy* aims to be truly multidisciplinary, for example, considering work in epidemiology, modelling, economics, criminology and law, psychology, sociology, anthropology, cultural studies, and historical and policy analyses. The journal is accepting of longer length papers, especially for qualitative, ethnographic and historical analyses, and is encouraging of critical and methodological work. It is the policy of the journal to represent a wide range of material on drug-related matters from around the world.

We are happy to advise you on submissions. Please contact Professor Gerry Stimson (gerry.stimson@gmail.com), Professor Tim Rhodes (tim.rhodes@lshtm.ac.uk) or the Editorial Office at ijdp@elsevier.com.

Following the advice below will expedite the review of your manuscript. This advice is also available on the journal's website: <http://www.elsevier.com/locate/drugpo>.

#### *Readership*

The journal has a broad readership drawn from the variety of disciplines working in the area of licit and illicit drug use and drug policy, including those working in: public health and epidemiology; social science; evaluation; community, education and welfare services; criminal justice; policy and advocacy; and human rights. The journal has an international readership.

#### *Types of manuscripts*

The journal encourages the submission of the following types of manuscript:

**Editorial:** These are usually between 1,500 and 2,000 words. Editorials do not have abstracts.

**Commentary:** These are usually between 2,500 and 4,000 words, and seek to explore in depth a particular topic or issue for debate, and may also include evidence and analysis. The Editor may invite expert responses to commentaries for publication in the same issue. Unstructured abstract.

**Review:** These are usually between 4,000 and 8,000 words, and seek to review systematically a particular area of research, intervention, or policy.

**Research paper:** These are usually between 3,000 and 5,000 words, but we also consider longer length papers up to 8,000 words. Research papers are usually based on original empirical analyses, but may also be discursive critical essays. Structured abstract.

**Short report:** These can be up to 2,000 words, an abstract of no more than 200 words, with one table, and no more than fifteen references. Structured abstract.

**Policy analysis:** These are focused specifically around contemporary or historical analyses of policies and their impacts, and are usually between 3,000 and 5,000 words, and exceptionally up to 8,000 words. Unstructured abstract.

**Viewpoint:** Short comments and opinion pieces of up to 1200 words which raise an issue for discussion, or comprise a case report on an issue relevant to research, policy or practice. No abstract and a maximum of ten references.

**Response:** Responses are short comments on papers published in the current or previous issues. They are usually between 500 and 1,000 words. Responses do not require abstracts.

### BEFORE YOU BEGIN

#### *Ethics in publishing*

For information on Ethics in publishing and Ethical guidelines for journal publication see <https://www.elsevier.com/publishingethics> and <https://www.elsevier.com/journal-authors/ethics>.

### **Conflict of interest**

All authors are requested to disclose any actual or potential conflict of interest including any financial, personal or other relationships with other people or organizations within three years of beginning the submitted work that could inappropriately influence, or be perceived to influence, their work. See also <https://www.elsevier.com/conflictsofinterest>. Further information and an example of a Conflict of Interest form can be found at: [http://service.elsevier.com/app/answers/detail/a\\_id/286/supporthub/publishing](http://service.elsevier.com/app/answers/detail/a_id/286/supporthub/publishing).

### **Submission declaration and verification**

Submission of an article implies that the work described has not been published previously (except in the form of an abstract or as part of a published lecture or academic thesis or as an electronic preprint, see <https://www.elsevier.com/sharingpolicy>), that it is not under consideration for publication elsewhere, that its publication is approved by all authors and tacitly or explicitly by the responsible authorities where the work was carried out, and that, if accepted, it will not be published elsewhere in the same form, in English or in any other language, including electronically without the written consent of the copyright-holder. To verify originality, your article may be checked by the originality detection service CrossCheck <https://www.elsevier.com/editors/plagdetect>.

### **Changes to authorship**

Authors are expected to consider carefully the list and order of authors **before** submitting their manuscript and provide the definitive list of authors at the time of the original submission. Any addition, deletion or rearrangement of author names in the authorship list should be made only **before** the manuscript has been accepted and only if approved by the journal Editor. To request such a change, the Editor must receive the following from the **corresponding author**: (a) the reason for the change in author list and (b) written confirmation (e-mail, letter) from all authors that they agree with the addition, removal or rearrangement. In the case of addition or removal of authors, this includes confirmation from the author being added or removed.

Only in exceptional circumstances will the Editor consider the addition, deletion or rearrangement of authors **after** the manuscript has been accepted. While the Editor considers the request, publication of the manuscript will be suspended. If the manuscript has already been published in an online issue, any requests approved by the Editor will result in a corrigendum.

### **Copyright**

Upon acceptance of an article, authors will be asked to complete a 'Journal Publishing Agreement' (for more information on this and copyright, see <https://www.elsevier.com/copyright>). An e-mail will be sent to the corresponding author confirming receipt of the manuscript together with a 'Journal Publishing Agreement' form or a link to the online version of this agreement.

Subscribers may reproduce tables of contents or prepare lists of articles including abstracts for internal circulation within their institutions. Permission of the Publisher is required for resale or distribution outside the institution and for all other derivative works, including compilations and translations (please consult <https://www.elsevier.com/permissions>). If excerpts from other copyrighted works are included, the author(s) must obtain written permission from the copyright owners and credit the source(s) in the article. Elsevier has preprinted forms for use by authors in these cases: please consult <https://www.elsevier.com/permissions>.

For open access articles: Upon acceptance of an article, authors will be asked to complete an 'Exclusive License Agreement' (for more information see <https://www.elsevier.com/OAauthoragreement>). Permitted third party reuse of open access articles is determined by the author's choice of user license (see <https://www.elsevier.com/openaccesslicenses>).

### **Author rights**

As an author you (or your employer or institution) have certain rights to reuse your work. For more information see <https://www.elsevier.com/copyright>.

### **Role of the funding source**

You are requested to identify who provided financial support for the conduct of the research and/or preparation of the article and to briefly describe the role of the sponsor(s), if any, in study design; in the collection, analysis and interpretation of data; in the writing of the report; and in the decision to submit the article for publication. If the funding source(s) had no such involvement then this should be stated.

### **Funding body agreements and policies**

Elsevier has established a number of agreements with funding bodies which allow authors to comply with their funder's open access policies. Some authors may also be reimbursed for associated publication fees. To learn more about existing agreements please visit <https://www.elsevier.com/fundingbodies>.

After acceptance, open access papers will be published under a noncommercial license. For authors requiring a commercial CC BY license, you can apply after your manuscript is accepted for publication.

### **Open access**

This journal offers authors a choice in publishing their research:

#### **Open access**

- Articles are freely available to both subscribers and the wider public with permitted reuse
- An open access publication fee is payable by authors or on their behalf e.g. by their research funder or institution

#### **Subscription**

- Articles are made available to subscribers as well as developing countries and patient groups through our universal access programs (<https://www.elsevier.com/access>).
- No open access publication fee payable by authors.

Regardless of how you choose to publish your article, the journal will apply the same peer review criteria and acceptance standards.

For open access articles, permitted third party (re)use is defined by the following Creative Commons user licenses:

*Creative Commons Attribution-NonCommercial-NoDerivs (CC BY-NC-ND)*

For non-commercial purposes, lets others distribute and copy the article, and to include in a collective work (such as an anthology), as long as they credit the author(s) and provided they do not alter or modify the article.

#### **Sponsored Articles**

*International Journal of Drug Policy* supports sustainable open access options, and offers authors the option to sponsor non-subscriber access to individual articles. The charge for article sponsorship is \$2500. Authors can only select this option after receiving notification that their article has been accepted for publication. This prevents a potential conflict of interest where a journal would have a financial incentive to accept an article. Authors who have had their article accepted and who wish to sponsor their article to make it available to non-subscribers should complete and submit the [order form](#).

Sponsored Articles have a specific set of user rights - for more information, [please follow this link](#).

The open access publication fee for this journal is **\$ 2500**, excluding taxes. Learn more about Elsevier's pricing policy: <http://www.elsevier.com/openaccesspricing>.

### **Green open access**

Authors can share their research in a variety of different ways and Elsevier has a number of green open access options available. We recommend authors see our green open access page for further information (<http://elsevier.com/greenopenaccess>). Authors can also self-archive their manuscripts immediately and enable public access from their institution's repository after an embargo period. This is the version that has been accepted for publication and which typically includes author-incorporated changes suggested during submission, peer review and in editor-author communications. Embargo period: For subscription articles, an appropriate amount of time is needed for journals to deliver value to subscribing customers before an article becomes freely available to the public. This is the embargo period and it begins from the date the article is formally published online in its final and fully citable form.

This journal has an embargo period of 12 months.

### **Language (usage and editing services)**

Please write your text in good English (American or British usage is accepted, but not a mixture of these). Authors who feel their English language manuscript may require editing to eliminate possible grammatical or spelling errors and to conform to correct scientific

English may wish to use the English Language Editing service available from Elsevier's WebShop (<http://webshop.elsevier.com/languageediting/>) or visit our customer support site (<http://support.elsevier.com>) for more information.

### Submission

Our online submission system guides you stepwise through the process of entering your article details and uploading your files. The system converts your article files to a single PDF file used in the peer-review process. Editable files (e.g., Word, LaTeX) are required to typeset your article for final publication. All correspondence, including notification of the Editor's decision and requests for revision, is sent by e-mail.

### Referees

Please submit the names and institutional e-mail addresses of several potential referees. For more details, visit our [Support site](#). Note that the editor retains the sole right to decide whether or not the suggested reviewers are used.

## PREPARATION

### Essential title page information

- **Title.** Concise and informative. Titles are often used in information-retrieval systems. Avoid abbreviations and formulae where possible.
- **Author names and affiliations.** Please clearly indicate the given name(s) and family name(s) of each author and check that all names are accurately spelled. Present the authors' affiliation addresses (where the actual work was done) below the names. Indicate all affiliations with a lower-case superscript letter immediately after the author's name and in front of the appropriate address. Provide the full postal address of each affiliation, including the country name and, if available, the e-mail address of each author.
- **Corresponding author.** Clearly indicate who will handle correspondence at all stages of refereeing and publication, also post-publication. **Ensure that the e-mail address is given and that contact details are kept up to date by the corresponding author.**
- **Present/permanent address.** If an author has moved since the work described in the article was done, or was visiting at the time, a 'Present address' (or 'Permanent address') may be indicated as a footnote to that author's name. The address at which the author actually did the work must be retained as the main, affiliation address. Superscript Arabic numerals are used for such footnotes.

### Abstracts

- On the second page, include the title of the paper, between 3-6 keywords, and an abstract of between 150 and 300 words.
- **Structured abstract:** We recommend these for: Research papers, Review papers, Policy Analysis, and Short reports. **Please adhere to the following mandatory abstract headings:** background, methods, results, conclusion.
- **Unstructured (plain) abstract:** We recommend these for: Commentaries, Historical Analysis, Review Essays, as well as for Research and Review papers where a plain abstract is better suited, as is the case with some social science submissions.
- **No abstract:** Editorials, Responses, Case Reports, Conference Reports.

### House style

- Please write in a clear style for an international readership. We are an international journal and many of our readers do not have English as a first language. Avoid (or explain) colloquialisms.
- Keep the text style and sub-headings simple. Text should preferably be in Times New Roman or Arial, 10-12 font, with double line spacing.
- Spelling is English (not American)
- All pages should be numbered at the bottom
- We do not normally like footnotes (but recognise that they are necessary for some styles of writing). Only use footnotes when absolutely necessary (otherwise incorporate into text).
- Keep tables simple. Do not duplicate information in the text. Include all tables and figures on separate sheets at the end; indicate in the text where these should be placed.
- Include in the acknowledgements any funding source for the work
- IJDP favours clear organisation of papers, an economical writing style, and a modest tone.



• IJDP requires all submissions to incorporate a clear and sufficiently detailed account of methods of data collection and analysis, including in Review Papers, Policy Analysis and Historical Analysis. IJDP encourages qualitative and ethnographic research submissions to sufficiently account for, and reflect upon, how data were analysed.

### **Graphical abstract**

Although a graphical abstract is optional, its use is encouraged as it draws more attention to the online article. The graphical abstract should summarize the contents of the article in a concise, pictorial form designed to capture the attention of a wide readership. Graphical abstracts should be submitted as a separate file in the online submission system. Image size: Please provide an image with a minimum of 531 × 1328 pixels (h × w) or proportionally more. The image should be readable at a size of 5 × 13 cm using a regular screen resolution of 96 dpi. Preferred file types: TIFF, EPS, PDF or MS Office files. See <https://www.elsevier.com/graphicalabstracts> for examples.

Authors can make use of Elsevier's Illustration and Enhancement service to ensure the best presentation of their images and in accordance with all technical requirements: [Illustration Service](#).

### **Highlights**

Highlights are mandatory for this journal. They consist of a short collection of bullet points that convey the core findings of the article and should be submitted in a separate editable file in the online submission system. Please use 'Highlights' in the file name and include 3 to 5 bullet points (maximum 85 characters, including spaces, per bullet point). See <https://www.elsevier.com/highlights> for examples.

### **Electronic artwork**

#### **General points**

- Make sure you use uniform lettering and sizing of your original artwork.
- Embed the used fonts if the application provides that option.
- Aim to use the following fonts in your illustrations: Arial, Courier, Times New Roman, Symbol, or use fonts that look similar.
- Number the illustrations according to their sequence in the text.
- Use a logical naming convention for your artwork files.
- Provide captions to illustrations separately.
- Size the illustrations close to the desired dimensions of the published version.
- Submit each illustration as a separate file.

A detailed guide on electronic artwork is available on our website:

<https://www.elsevier.com/artworkinstructions>.

**You are urged to visit this site; some excerpts from the detailed information are given here.**

#### **Formats**

If your electronic artwork is created in a Microsoft Office application (Word, PowerPoint, Excel) then please supply 'as is' in the native document format.

Regardless of the application used other than Microsoft Office, when your electronic artwork is finalized, please 'Save as' or convert the images to one of the following formats (note the resolution requirements for line drawings, halftones, and line/halftone combinations given below):

EPS (or PDF): Vector drawings, embed all used fonts.

TIFF (or JPEG): Color or grayscale photographs (halftones), keep to a minimum of 300 dpi.

TIFF (or JPEG): Bitmapped (pure black & white pixels) line drawings, keep to a minimum of 1000 dpi.

TIFF (or JPEG): Combinations bitmapped line/half-tone (color or grayscale), keep to a minimum of 500 dpi.

#### **Please do not:**

- Supply files that are optimized for screen use (e.g., GIF, BMP, PICT, WPG); these typically have a low number of pixels and limited set of colors;
- Supply files that are too low in resolution;
- Submit graphics that are disproportionately large for the content.

### **References**

**Text:** Citations in the text should follow the referencing style used by the American Psychological Association. You are referred to the Publication Manual; of the American Psychological Association, Fourth Edition, ISBN 1-55798-243-0, copies of which may be ordered from PAP Order Dept, P.O.B. 2710 Hyattsville, MD 20784, USA or APA, 3 Henriette Street, London EC3E 8LU, UK.

Details concerning this referencing style can also be found at <http://humanities.byu.edu/linguistics/henrichsen/APA/APA01.html>



**List:** References should be arranged first alphabetically and then further sorted chronologically if necessary. More than one reference from the same author(s) in the same year must be identified by the letters "a", "b", "c" etc placed after the year of publication.

## Examples

Reference to a **journal** publication:

Van der Geer, J., Hanraads, J.A.J., & Lupton, R.A. (2000). The art of writing a scientific article. *Journal of Scientific Communications*, 163, 51-59

Reference to a **book**:

Strunk, W., Jr., & White, E.B. (1979). *The elements of style*. (3rd ed.) New York: Macmillan, (Chapter 4).

Reference to a **chapter** in an edited book:

Mettam, G. R., & Adams, L. B. (1994). How to prepare an electronic version of your article. In B. S. Jones, & R. Z. Smith (Eds), *Introduction to the electronic age* (pp.281-304. New York: E-Publishing inc.

Reference to a **website** must contain the date on which the information was retrieved:

Gerlach R, Schneider W. Injecting room at INDRO, Munster, Germany. Retrieved 2nd June 2002 from <http://www.indro-online.de/sir.htm>

### Reference links

Increased discoverability of research and high quality peer review are ensured by online links to the sources cited. In order to allow us to create links to abstracting and indexing services, such as Scopus, CrossRef and PubMed, please ensure that data provided in the references are correct. Please note that incorrect surnames, journal/book titles, publication year and pagination may prevent link creation. When copying references, please be careful as they may already contain errors. Use of the DOI is encouraged.

### Reference management software

Most Elsevier journals have their reference template available in many of the most popular reference management software products. These include all products that support Citation Style Language styles (<http://citationstyles.org>), such as Mendeley (<http://www.mendeley.com/features/reference-manager>) and Zotero (<https://www.zotero.org/>), as well as EndNote (<http://endnote.com/downloads/styles>). Using the word processor plug-ins from these products, authors only need to select the appropriate journal template when preparing their article, after which citations and bibliographies will be automatically formatted in the journal's style. If no template is yet available for this journal, please follow the format of the sample references and citations as shown in this Guide.

Users of Mendeley Desktop can easily install the reference style for this journal by clicking the following link:

<http://open.mendeley.com/use-citation-style/international-journal-of-drug-policy>

When preparing your manuscript, you will then be able to select this style using the Mendeley plug-ins for Microsoft Word or LibreOffice.

### Reference formatting

There are no strict requirements on reference formatting at submission. References can be in any style or format as long as the style is consistent. Where applicable, author(s) name(s), journal title/book title, chapter title/article title, year of publication, volume number/book chapter and the pagination must be present. Use of DOI is highly encouraged. The reference style used by the journal will be applied to the accepted article by Elsevier at the proof stage. Note that missing data will be highlighted at proof stage for the author to correct. If you do wish to format the references yourself they should be arranged according to the following examples:

## AudioSlides

The journal encourages authors to create an AudioSlides presentation with their published article. AudioSlides are brief, webinar-style presentations that are shown next to the online article on ScienceDirect. This gives authors the opportunity to summarize their research in their own words and

to help readers understand what the paper is about. More information and examples are available at <https://www.elsevier.com/audioslides>. Authors of this journal will automatically receive an invitation e-mail to create an AudioSlides presentation after acceptance of their paper.

### **Supplementary material**

Supplementary material can support and enhance your scientific research. Supplementary files offer the author additional possibilities to publish supporting applications, high-resolution images, background datasets, sound clips and more. Please note that such items are published online exactly as they are submitted; there is no typesetting involved (supplementary data supplied as an Excel file or as a PowerPoint slide will appear as such online). Please submit the material together with the article and supply a concise and descriptive caption for each file. If you wish to make any changes to supplementary data during any stage of the process, then please make sure to provide an updated file, and do not annotate any corrections on a previous version. Please also make sure to switch off the 'Track Changes' option in any Microsoft Office files as these will appear in the published supplementary file(s). For more detailed instructions please visit our artwork instruction pages at <https://www.elsevier.com/artworkinstructions>.

### **Submission of manuscripts**

The *International Journal of Drug Policy* uses an online, electronic submission system. By accessing the website <http://ees.elsevier.com/drugpo/> you will be guided stepwise through the creation and uploading of the various files. When submitting a manuscript to Elsevier Editorial System, authors need to provide an electronic version of their manuscript. Authors may send queries concerning the submission process, manuscript status, or journal procedures to the Editorial Office:

Elsevier Ireland Ltd., Brookvale Plaza, East Plaza, Shannon, Co. Clare, Ireland, Fax: +353 61 709250, [ijdp@elsevier.com](mailto:ijdp@elsevier.com). This address should also be used to submit multimedia files

Once the uploading is done, the system automatically generates an electronic (PDF) proof, which is then used for reviewing. All correspondence, including the Editor's decision and request for revisions, will be by e-mail.

### **Authors' responsibilities**

By submitting material for publication the authors warrant

- that it is their original work and that it has not been published in whole or in part elsewhere and is not under consideration by any other journal. If any part of the material has been or is being published elsewhere the authors should state this in an accompanying letter.
- that all persons named as authors have made a major contribution to the work reported, and are prepared to take public responsibility for its contents. Participation solely in the acquisition of funding or the collection of data does not justify authorship.

All authors must give signed consent to publication.

### **Submission checklist**

The following list will be useful during the final checking of an article prior to sending it to the journal for review. Please consult this Guide for Authors for further details of any item.

#### **Ensure that the following items are present:**

One author has been designated as the corresponding author with contact details:

- E-mail address
- Full postal address

All necessary files have been uploaded, and contain:

- Keywords
- All figure captions
- All tables (including title, description, footnotes)

Further considerations

- Manuscript has been 'spell-checked' and 'grammar-checked'
- References are in the correct format for this journal
- All references mentioned in the Reference list are cited in the text, and vice versa
- Permission has been obtained for use of copyrighted material from other sources (including the Internet)

Printed version of figures (if applicable) in color or black-and-white

- Indicate clearly whether or not color or black-and-white in print is required.

For any further information please visit our customer support site at <http://support.elsevier.com>.

## **AFTER ACCEPTANCE**

### **What happens after we receive your manuscript?**

#### **Manuscript acknowledgement**

Corresponding authors will be sent an acknowledgement that their manuscript has been received.

#### **Review of manuscripts**

**Initial review:** On receipt all manuscripts are seen by one of the Editors to assess overall suitability for publication in IJDP in terms of topic area and quality. A paper may be rejected at this stage if it falls outside the journals aims and scope; if there are obvious problems with presentation, argument or research; or if it is unoriginal. The Editor will seek advice from another Editor, Associate Editor, or member of the Editorial Board before making a decision to reject at this stage.

**Full peer review:** After passing initial review, submissions are assigned to one of the Editors or Associate Editors. Manuscripts are sent to peer reviewers and the Author is not blinded to the Reviewer. Reviewers advise the Editors, who are responsible for the final decision to accept or reject a manuscript. Peer reviewers are asked to respond within three weeks and are asked to rate the paper and to include comments for the Editors and for the authors. We aim to get a quick decision for authors, but review and appraisal by the editors is normally a minimum of eight weeks and can on occasions be longer. We aim to inform you if there is a delay. If you want information about progress please email the editorial office. All material accepted for publication may be subject to editorial revision. If your article is accepted for publication you will receive a proof copy from the Publisher. It is your responsibility to read, correct and return the proof within 48 hours.

#### **Proofs and page charge**

One set of proofs will be sent to the corresponding author. No alteration of the substance of the text, tables, or figures will be allowed at this stage. Corrected proofs should be returned to the publisher within two days of receipt. Authors who submit to the journal will be given access to Elsevier's On-Line Author Status Information System (OASIS). They will receive a personal identification code together with the acknowledgement letter sent upon receipt of their manuscript. This code will grant them access to the OASIS site on the internet, allowing them to track the status of their manuscript. Authors may also access Elsevier's central Log-in Department e-mail address for any specific questions they may have regarding the publication of their manuscript. The International Journal of Drug Policy carries no page charges.

#### **Offprints**

The corresponding author, at no cost, will be provided with a PDF file of the article via e-mail. For an extra charge, paper offprints can be ordered via the offprint order form which is sent once the article is accepted for publication. The PDF file is a watermarked version of the published article and includes a cover sheet with the journal cover image and a disclaimer outlining the terms and conditions of use.

#### **Use of the Digital Object Identifier**

The Digital Object Identifier (DOI) may be used to cite and link to electronic documents. The DOI consists of a unique alpha-numeric character string which is assigned to a document by the publisher upon the initial electronic publication. The assigned DOI never changes. Therefore, it is an ideal medium for citing a document, particularly 'Articles in press' because they have not yet received their full bibliographic information. Example of a correctly given DOI (in URL format; here an article in the journal *Physics Letters B*):

<http://dx.doi.org/10.1016/j.physletb.2010.09.059>

When you use a DOI to create links to documents on the web, the DOIs are guaranteed never to change.

### **Offprints**

The corresponding author, at no cost, will be provided with a personalized link providing 50 days free access to the final published version of the article on [ScienceDirect](#). This link can also be used for sharing via email and social networks. For an extra charge, paper offprints can be ordered via the offprint order form which is sent once the article is accepted for publication. Both corresponding and co-authors may order offprints at any time via Elsevier's WebShop (<http://webshop.elsevier.com/myarticleservices/offprints>). Authors requiring printed copies of multiple articles may use Elsevier WebShop's 'Create Your Own Book' service to collate multiple articles within a single cover (<http://webshop.elsevier.com/myarticleservices/booklets>).

### **AUTHOR INQUIRIES**

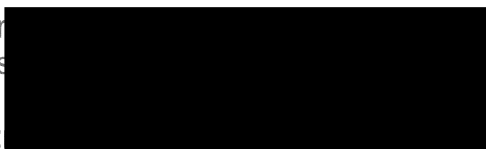
You can track your submitted article at <https://www.elsevier.com/track-submission>. You can track your accepted article at <https://www.elsevier.com/trackarticle>. You are also welcome to contact Customer Support via <http://support.elsevier.com>.

© Copyright 2014 Elsevier | <http://www.elsevier.com>

## **Appendix C: Ethics approvals for empirical study**

Date: 22 April 2015  
Your Ref.: 15/SS/0039

Enquiry  
Extension  
Direct  
Email:



Dr Luisa S Frei  
Trainee Clinical Psychologist  
NHS Lothian



Dear Dr Frei

<b>Study title:</b>	<b>Fatherhood and drugs – how men with problem opiate use experience fatherhood</b>
<b>REC reference:</b>	<b>15/SS/0039</b>
<b>IRAS project ID:</b>	<b>163791</b>

Thank you for your letter responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Manager, Miss Manx Neill,

████████████████████ . Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

### **Confirmation of ethical opinion**

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

### **Conditions of the favourable opinion**

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations



## Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact [hra.studyregistration@nhs.net](mailto:hra.studyregistration@nhs.net). The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from NRES. Guidance on where to register is provided on the HRA website.

**It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

## **Ethical review of research sites**

### NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

### Non-NHS sites

The Committee has not yet completed any site-specific assessment (SSA) for the non-NHS research site(s) taking part in this study. The favourable opinion does not therefore apply to any non-NHS site at present. We will write to you again as soon as an SSA application(s) has been reviewed. In the meantime no study procedures should be initiated at non-NHS sites.



## Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
GP/consultant information sheets or letters [InfoHCP]	1	01 February 2015
GP/consultant information sheets or letters [LetterHCP]	2	24 January 2015
IRAS Checklist XML [Checklist_20042015]		20 April 2015
Letters of invitation to participant [Invitation]	2	24 January 2015
Other [LocCollab_CV]	1	08 December 2014
Other [DataSheet]	1	08 December 2014
Participant consent form [consent]	5	19 April 2015
Participant information sheet (PIS) [PIS]	5	19 April 2015
REC Application Form [REC_Form_20022015]		27 February 2015
Referee's report or other scientific critique report [feedbackUni]	1	06 August 2014
Research protocol or project proposal [protocol/proposal]	05	01 February 2015
Summary CV for Chief Investigator (CI) [CI_CV]	2	02 February 2015
Summary CV for supervisor (student research) [Supervisor_CV]	1	08 December 2014

## Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

## After ethical review

### Reporting requirements

The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

## User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: <http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>

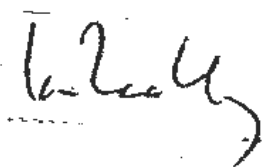
## HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

15/SS/0039	Please quote this number on all correspondence
------------	--

With the Committee's best wishes for the success of this project,

Yours sincerely

A handwritten signature in black ink, appearing to read 'I. Zealley', written over a horizontal dashed line.

**Dr Ian Zealley**  
Chair



Enclosures: "After ethical review – guidance for  
researchers" [\[SL-AR2\]](#)

Copy to: Ms Jo-Anne Robertson  
Ms Karen Haggart, NHS Lothian Research and Development

[REDACTED]  
FM/CK/approval

09/07/2015

Mrs Heather Simpson  
NHS Lothian  
[REDACTED]

Research & Development  
[REDACTED]

Director: Professor David E Newby

Dear Mrs Simpson

**Lothian R&D Project No:** 2015/0284

**Title of Research:** Fatherhood and drugs- how men with problem opiate use experience fatherhood

**REC No:** 15/SS/0039

**Participant Information Sheet:**

Version 05, 19 April 2015

HCP Version 01, 1 February 2015

**Protocol:**

Version 05, 1 February 2015

**Consent Form:**

Version 05, 19 April 2015

I am pleased to inform you that this study has been approved for NHS Lothian and you may proceed with your research, subject to the conditions below. This letter provides Site Specific approval for NHS Lothian.

Please note that the NHS Lothian R&D Office must be informed if there are any changes to the study such as amendments to the protocol, recruitment, funding, personnel or resource input required of NHS Lothian.

Substantial amendments to the protocol will require approval from the ethics committee which approved your study and the MHRA where applicable.

Please inform this office when recruitment has closed and when the study has been completed.

I wish you every success with your study.

Yours sincerely

*Fiona McArdle*

Ms Fiona McArdle  
Deputy R&D Director

CC: Dr Luisa Frei, Chief Investigator, University of Edinburgh  
Tim Montgomery, Director of Operations, Royal Edinburgh Hospital  
Dr Andrew Flapan, Associate Medical Director - Medicine Services, RIE

**From:** Lawrence, Rebecca  
**Sent:** 11 November 2014 13:58  
**To:** Frei, Luisa  
**Cc:** Littlewood, Peter  
**Subject:** RE: SMD research group meeting

Hi Luisa

Just to make clear – we are happy to support the project!

When we discussed this at our last meeting, we thought most of our queries would be answered during the ethics / management approval process. If you can let us know when this goes through, and send me copies of approval letters that would be great.

Best wishes

Rebecca

Dr Rebecca Lawrence  
MBChB, MPhil, MRCPsych  
Consultant Psychiatrist in Addictions  
Substance Misuse Directorate  
NHS Lothian  
[REDACTED]

**From:** CLINICAL PSYCHOLOGY Research Ethics  
**Sent:** 30 September 2015 15:54  
**To:** FREI Luisa  
**Subject:** Re: Ethics form, study registration

Dear Luisa,

Yes, this is fine. We can log your REC approval. If you need to make any changes to the project I would be grateful if you could copy University Ethics into any correspondence arising.

Best wishes,

Angus

Angus MacBeth  
Lecturer in Clinical Psychology  
Ethics Tutor

---

**From:** FREI Luisa  
**Sent:** 24 September 2015 12:19  
**To:** CLINICAL PSYCHOLOGY Research Ethics  
**Subject:** Ethics form, study registration

Dear Angus,

I have attached the uni ethics form for my thesis. I have REC approval, so I've only filled in the study registration pages. I hope this is sufficient!

Best wishes,  
Luisa

## Appendix D: nVivo theme excerpt: 'Hands-on Father'

<Internals\FD01\_Billy> - § 2 references coded [1,67% Coverage]

Reference 1 - 0,79% Coverage

P: Aye. So like I says, for whatever reason, [26.07: unintelligible] as well, throughout it all. I seemed to function with my ... I was changing nappies when I was an alcoholic, eh? There been a guy that's doing my ways, that's... [25.54]. For an era, four kids were involved, the mother of my kids, she had two older kids when I met her, so it was quite full on.	Doesn't seem to understand how his kids turned out so well despite his addiction, surprise of his apparent high functioning despite alcohol addiction Hands-on: changing nappies Function in father role with societal expectations Juggling demands of addiction and kids
---	---

Reference 2 - 0,88% Coverage

P: Well, usually my mum, I dinnae really leave M3 with people. Nah, there's nobody know along enough where I live, or somebody I'd leave him with. Aye, if I've got my ma, my social life doesnae really... we go to Hibs games together, that's me and M3's social life, so and he's with me. Now and again when I do have somewhere to go, my mum will do it, but it's ... Like I say, I've never really gone out much.	Not relying on anyone but mother for childcare, too precious to leave with people he doesn't know well enough Social life revolves around child Activities with kids, football  Isolation, avoidance Overcompensation with presence?
---	---

<Internals\FD02\_John> - § 2 references coded [2,61% Coverage]

Reference 1 - 1,98% Coverage

P: I'm good with them. She says I'm a really good dad.	nice dad
I: And what does that mean?	
P: Em, well, I play with them in the park, I always make time for them, they always come first. Whatever she wants to do, that's what we do. I was like that with my boys as well. I used to get them on a Sunday, every Sunday, regardless how I felt or whatever. I could be out Saturday night on the coke, cause it was coke then, it was not heroin. And there's coke then, but on Saturday... on Sunday, I was always up on Sunday, always, regardless of what rain, shine, ill, not, I'd still make it to see the kids. And I'd say "Right, where do you wanna go?" and it'd be [four different areas in Edinburgh] somewhere on a Sunday. They'd pick it and I'd take them. And same with the girls. I'd say "Right, where'd you wanna go? What park?" I'd say "Right, I'll meet you in the park in half an hour or an hour"	important to spend time with children, fulfilling their every wish hands-on  consistency, reliability  wants to be there for them and not disappoint them  fulfils their every wish?

Reference 2 - 0,63% Coverage

P: Em, I've been to the museum with them, I've been to the castle with them, took them to the castle and that, to see the dungeon, really. Telling them about the jewels, the crown jewels, she wanted to see them, the crown and them. Aye, I took her to the castle. I've had her loads of places, actually. I had her down to [area], down at [area], aye.	likes to do stuff with them, taking them out
---	--

<Internals\FD03 Chris> - § 3 references coded [2,16% Coverage]

Reference 1 - 0,20% Coverage

How would I explain myself as a dad? No, I'm very hands on when able.	Hands-on dad disability
<b>Okay</b>	
Very hands on when able but eh	

Reference 2 - 1,83% Coverage

When I'm able, yeah, when I'm able, aye, my, the, my daughters see me as like a goofball, ken.	Goofball, entertaining
<b>Oh right</b>	
My wife's, my wife's the serious one and I'm, I'm their playmate and stuff, ken. My eldest, I mean I'm there just if she wants something, Dad can you drop me here or can you come to the bus stop at half 10 to meet me cause it's dark and	Playmate, role sharing, practical dad, awareness of needs of different ages providing safety
<b>Uhuh</b>	
ken that's my role with my eldest one, but with my youngest one aye, I, I'm her play toy. I need to be there to, she's got so much energy and stuff I need to be there to keep her, even, even if she's watching the TV, my daughter she'll be watching TV on the stool and then she'll get up and the stool will be upsides down and then she'll get, she just can't sit still so aye, I'm, when I'm able I'm very, very hands on and aye, always, always where I'm coming up with things that, to try and I'm not, I'm not a dad who, I don't, not that I don't think that she's safe but I think that F2's not got the, the mentality yet to be out with like friends her age.	Different roles with different ages Looking after younger one, thinking for her, taking responsibility for her safety, understanding her state of mind, good mentalising

Reference 3 - 0,12% Coverage



aye, so aye that, that's like I say when I'm able [laughing] aye, very hands on, aye.	Disability through drugs
---	--------------------------

<Internals\FD06 Iain> - § 1 reference coded [0,61% Coverage]

Reference 1 - 0,61% Coverage

Aye, yeah. Probably a lot of my idea, probably my perception of what it was going to be like when M1 was born or even before he was born, just thinking about it, I cannae wait to do all this stuff that dad's do. Take him to the football, take him fishing, and be with him and provide for him. But that, in a sense was taken away from me, and also in a sense I kinda gave it up. Em, because I chose to continue the addiction going rather than trying to fight it out for my son.	intergenerational transmission, role model  hands-on wants to do same with his son, enjoys being a dad, excited about it  fels guilty for giving it up, blaming himself
--	--

<Internals\FD07 Jack> - § 1 reference coded [1,87% Coverage]

Reference 1 - 1,87% Coverage

<b>So what was he like with you, with his, with his children?</b>	
He was great. He was great. He used to love going to the tips, know	
<b>The tips?</b>	
The tips, yeah.	
<b>What's that?</b>	
The tips, like years ago down [street], he used to put a tip there and they used to put all wee motorbikes and stuff and my dad would make wee motorbikes up for me and I'd run about the tip with them, ken. My dad, he was	Dad hands-on, very involved in practical outings
<b>Sounds like he was very involved with you, yeah?</b>	
Yeah, aye, aye. I'm like that, ken, if I see something that's nice in a skip I'll go and tap the door, is it alright to take, ken, I think I've got that fae ma dad cause they were the best times I could remember with my dad. I can't remember much with my dad, but I can remember running about like he'd get a motorbike, ken he'd fix up a wee motorbike in seconds and let me run about and	Enjoyed going out with dad, best memory Bonding over motor bikes Thinks he's like him

he'd take the copper and stuff like that and sell it on, know. I know, a crazy life but	
---	--

<Internals\FD08\_Steve> - § 6 references coded [11,15% Coverage]

Reference 1 - 4,80% Coverage

Eh, I would like to just do like normal stuff. To be honest with you. It starts at very basic with me, cause 3h a week with two kids that are different ages and different sexes is very very hard to juggle. 4 hours.	normal stuff, everyday things, not enough time to do special things
<b>So what do you do with them, then?</b>	
Ah...	
<b>What is the normal stuff?</b>	
Well, sometimes, it can differ, usually weather plays a part in that, but like, ken, sitting and watch a video or we'll sit and we'll make things or we'll paint or we'll draw or destroy things as well [chuckles], like playing and tumbling things down the stairs or... We made like a, a wee, inside the house, my mum goes to costco and buys like packets of toilet roll, packets! So we made a toilet roll house yesterday, just inside the house, for a wee while and then we went out picking berries, and different sort of petals and stuff, to let them see what smells and stuff there was, and ...	likes to do all hands-on stuff, get to know them, interact with them, teach them and learn from them, lots of time for bonding
<b>Sounds lovely..</b>	
... and we were picking cherries yesterday, em my youngest daughter was explaining to me why certain berries were left on bushes, and – I don't know if it's true, but she says – I'm assuming it's true, she says, Daddy the reason that these berries are left – I thought it was because the birds dinnae like them, but she says it's cause they were really, really, really, really jaggy to get in. So the birds don't like landing on them.	
<b>Ok...</b>	
Cause they jag their feet. Whether that's true or not, there is some sort of sense there, so it could be. Em...	
<b>It sounds nice, it sounds like you're very involved with them, you play with them, you talk to them.</b>	
Yeah, mh. Just not enough...	cannot be the dad he wants
<b>Not enough?</b>	
...it feels, do you know what I mean?	

Reference 2 - 1,69% Coverage

Em, I would like to be ... I would... do you know, if I could ... I know what I wanna be and what I wanna do and I'm doing it, right, but I'm... it's	feels he is the dad he wants to be, but doesn't get the opportunity to do it finds it difficult to out this into words
---	--

<p>just... if I could get more access to do it. Like I would, what I would like to do is like allocate some of my time to my son, and some of my time to my daughter, and then time with the both of them, together. Because two different kids, and different ages and one's a wee boy and one's a girl, they've got different things. And it's hard trying to find that, it's hard trying to say, ok I've only got 3h, what am I gonna do that both of them like? It's very easy to fall into a trap where you're doing the same thing just to keep peace, or, em... I... it's good that they're at the age that – cause I usually ask them what they want to do now, and within reason, that can happen. Em, even, what I like doing with them, or they like doing, is going to go along to like [garden centre], and then we can have a look at plants and, em, we like these outside patio huts, that you can sit in, em.... I like being out and about, I was brought up on a farm, so, it was like... I was out, and I was in fresh air, and there was nae computers and that's a fault I see with my kids, that there's this addiction. It's not just my kids, my brother's kids are probably worse actually. Em, they're just going straight for iPads or huddles or it's like a constant battle to distract them from this, so I can do something a bit more hands-on, eh? So..</p>	<p>aware of dividing his time and attention between the two, different personalities and sexes</p> <p>finds it hard to cater for both of them in such a short time</p> <p>doesn't want to have a boring routine</p> <p>likes to do things with them that he liked to do as a child</p> <p>values: wants kids to experience world beyond the digital world</p> <p>recognises addiction for computers</p> <p>very hands-on</p>
---	--

Reference 3 - 1,53% Coverage

<p>Eh, it was actually not bad, eh, I personally, I done a lot as a dad. I would get up and do night feeds, I was taking them into nursery, I was picking them up from nursery, I would make the bottles at night before they were getting done, I would change nappies... Because my partner worked, I made sure that I was doing as much as I could, tea was ready for her coming in, and they would be bathed every night, and the kids were always looked after, eh? Em... if there was ever a point where I didnae think I was gonna be 100% to look after the kids, I would get my mum and dad to look after them...</p>	<p>he was hands-on with infant care and child care, supporting his partner, being responsible</p> <p>idea of how father should be, but this does not include bonding with children</p> <p>recognising own weakness, what effect did that have on kids?</p>
--	--

Reference 4 - 0,68% Coverage

<p>Em, ...trying to think... em...I would probably like to do more hands-on stuff with them, em and sit and, like, cause I never do homework with them or that, cause obviously that's a, not my time on a Sunday afternoon, but like, doing more like homework and stuff...</p>	<p>is interested in their day to day life, wants to have a regular involvement in the normal, daily routine</p>
--	---